**		Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health are	nd Mental Hygiene
	-	1 - State of Maryland / Department of Floating and Certificate of Death	Reg. No. UII 100UI
Physici Med		Decedent's Name (First, Middle, Last) JOAN ANN MARRONE	2. Date of Death Month MAY 8 2011 Year 1:48P
Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of FREDERICK MEMORIAL HOSPITAL 4c. Facility Name (if not institution, give street and number) FREDERICK	Death 4c. County of Death F'REDERICK
Funera Directo		5. Social Security Number 214-28-0684 6. Sex 1	Hrs. 8. Date of Birth Min. July 22, Year 931 9. Birthplace (State or Foreign Marty Land
aryland ta-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick	10d. Inside City Limits Y☐ Yes 2 ☐ No
with the M 23a or 28 Ist be not	Funeral Director	10e. Street and Number 2140 Wainwright Ct., Unit 2B 10f. Zip Code 21702	10g. Citizen of What Country? U.S.A.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, specify Cuban, Mexican, 1 Yes No If Yes, Give Year or Dates.	12 (Specify Yes or No-Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	of working Dental Office
land Mental Hyginked other	To Be	17. Father's Name (First, Middle, Last) Charles Troxell 18. Mother Ev	s Name (First, Middle, Maiden Surname) elyn Butler
Mary d 2 should alth and M 27 is ma		19a. Informant's Name/Relationship (Type, Print) Mr. James G. Marrone, Sr. Hus. 2140 Wainwright Ct	or Rural Route Number, City or Town, State, Zip Code , Unit 2B, Frederick, MD 21702
Baltimore, permit. Page 1 and Department of Heal mportant: If item may injury or other man.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Zion Lutheran Cemetery	May 12, 2011 Middletown, MD
Balti permit. P Departm Importa any inju		M00255 106 East Church	ford PA Funeral Home St., Frederick, MD 21701
Ph, siciar		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one on second each line. Immediate Cause (Final	ardiac or respiratory arrest, Approximate Interval Between Onset and Death
Medica Examine	l r	resulting in death) ue to (or as a consequence of):	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	
be executed ysician and burial-transi	<u>=</u>		
, P.O. Box 68760 ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	23d. Date of delivery Month Day Year
S, P.O. ires that the signed by t	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director. After this certificate has been signed by the funeral director, page 2 should be detach	omplete		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
fital Rec sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner? Hospital: Other:	h (Check only one) rsing Home 5 □ Residence 6 □ Other (Specify)
on of Vital F nding Physician: T th. After this certifica funeral director, g	cate: To		28d. Describe how injury occurred
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hospita 24 hours e Funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of the control of the con	curred at the time, date and place, and due to the cause(s) and marrier state
To the within 2 To the comple	2	29b. Signature and title of certifier 29c. License number	29d. Date signed (Monthy Day, Year)
SM		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WO TOWN DT DORDON LO TOWN DEST	th Street Frederick MD
S Regis	tate trar	31. Date filed (Month, Day Year) 32. Registrar's Signature	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 201 Tear Physician/ April 22, 9:30 P.M Margaret Routzahn Mullican Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 9541 Liberty Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 M 2 XF Months Days Hours Min. 06/07/1920 Director 90 213-16-0853 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland 10a. State **Funeral Director** 1 🗌 Yes 2 🖺 No Frederick Frederick MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may highry or other traumatic event, the Medical Examiner must be once. lusa 9541 Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 ¥ Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) department store clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Sophia Hobbs Edward C. Routzahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9549 Liberty Road, Frederick, MD 21701 Dwight Mullican/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Libertytown, MD Union Chapel 4/26/2011 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Fundral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ALZHEIMERS DEMENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): a ending physician as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown ed by the a endindetached for use 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MULTIPLE MYELOMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other:

or Attending Physician: The law requires that the dea h certificate be executed 68760 Box P.O. Division of Vital Records, ours after death.

Interest of the furth of

1 \(\text{Yes}

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

29b. Signature and title of certi-

RICHARD

29a. Certifier

2. No

5 Pending

Investigation 6 Could not be

determined

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 hours within 24 hou

To the Fune

completed fil

State

Medical

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Po

32. Registrar's Signature

Career .

28b. Time of

28c. Injury at work?

1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Jank.

1 Yes 2 No

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D32171

WALKERSUILLE

29c. License number

28a. Date of injury (Month, Day, Year)

4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

26/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 28 pay 2011 ear Physician/ 5:20 а м Julius McCallum George Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Potomac Liberty Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Jan• 21, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. Months Hours 1 X M 2 F United Kingdom Jan. 1931 220-38-3457 80 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State at with the Maryland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 🎛 No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 USA 5710 Sugarbush Lane items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Was Decedo... Armed Forces? 1 ☐ Yes 2XXNo Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 9 1 Never Married 2X Married þ permit, Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene, Important; If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Seconday (0-12) International Business Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Julius McCallum Darley Aitken 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5710 Sugarbush Lane, Rockville, MD 20852 Zena McCallum/Wife 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State April 2011 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins F
500 University Blvd. Funeral Home Inc. MD 20901 Part 1. Inter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dysphagia Medical Due to (or as a consequence of): Examiner 15 yrs Alzheimer's Disease Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury ending physician and are as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Month ģ Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, Cardiovascular Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 performed⁴ funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6xx Assisted Living examiner? Hospital 2K No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work after death.

I Director: Aft director in by the fur 1 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 🗌 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title certifie 28 D35579 201 s of person who completed cause of death (Item 23a) (Type, Print)
Miller, MD 8218 Wisconsin Avenue, #305, Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year, APR 29 2011

30. Name and address Susan J

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 26, 8:18 P M SUZANNE PURCELL MOHEN 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BERLIN ATLANTIC GENERAL HOSPITAL WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Min. Hours PENNSYLVANIA Director Yrs 209-42-8127 08/23/1951 59 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No MD WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9715 HEALTHWAY DRIVE UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. ö 1 Never Married 2 Married Completed by Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify "natural", 3 Widowed 4X Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPER CLEANING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or at MARY HANAGAN HOWARD PURCELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL MOHEN / SON 109 LINDSAY ROAD MILLINGTON, MARYLAND 21651 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 04/27/2011 STEVENSVILLE, MARYLAND FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A CYPRESS STREET MILLINGTON, MARYLAND 2165 3a. Part 1. Enter the disease, on complications that aused the death. Do not after the mode of rying, shock, or hear failure. List only one cause or bush line. Approximate erval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): sician and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Unknown the 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🕽 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director: After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nayse P actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d, Date signed (Month, Day, Year) 85 30. Name and address of per ed cause of death (Item 23a) (Type, Print) Rm un 61. Date filed (Month State 28 Registrar

26

750

20

95

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death Rea, No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5:58 PM 22 2011 KOBERT ARTHUR 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ENT FARM Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Yrs. MD 213 30 464 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No CHESTERTOWN MO KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 23441 FARM ACAWAY 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE INSURANCE AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MUORK MILDRED Ill ILLIAM GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23441 CAC 4 W FACA WE CHESTERTUS, MD 2K2 19a. Informant's Name/Relationship (Type. Print) WIFE LEE MARION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/25/2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER, MD 22. Name and Address of Ficility MARYIN V. WILLIAM, SE 205 GREEN HERSIN A 130 SPEER DOND. 21. Signature of Funeral Service Licensee 21620 · Will , mo CHESTERTON um 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MetastaTI Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1∏Yes 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of

Examine The law requires that the death certificate be executed use as the burial-transit and attending physician been signed by the s Division or Vital Records, page 2 s or Attending Physician:

Box 68760.

P.O. P

Physician

/Medical

Director

Funeral

Completed by

Be

ပို

Examiner

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. ?? is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at

permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trauonce.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical \$ Completed Be

funeral director,

Certification:

certificate After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

To the Hospital 10+ Rm

State Registrar

1 ☐ Yes 25 No 27. Manner of Death

29b. Signature and title of certifier

29a. Certifier

(Check only one)

5 ☐ Pending investigation 1. Natural 2 Accident 3 Suicide

6 Could not be determined 4 Homicide

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D0050996

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

23/2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Staddovd 31. Date filed (Month, APR 25

32. Registrar's Signature

100 Brown St Chaster town MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28 2011 Physician/ Eva Dolly Morrow 02:13 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Great Mills St. Mary's Chesapeake Shores 8. Date of Birth (Month, Day, Year) April 3 1923 Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🖳 F Hours 88 Mary Land 212-30-4573 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🙀 No Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2005 Adelina Road 20678 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Completed 3 🖵 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home 12th homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Samuel James Hooper Lindy A. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice LaRocca - daughter P.O. Box 17 Charlotte Hall MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Central Cemetery May 2, 2011 Barstow Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Fund 144o5 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ UN KNOWN Medical resulting in death) Due to (or as a consequence of) Examiner JHK400M Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform MONARL After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: work? 1 Natural 2 Accident 5 Pending 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: of the formula in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Kleman MD 401 Centennial Ave LaPlata MD 20747 32. Registra s Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 2011 Physician/ 6:30 am Norman Walter Mencer, Jr. Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs **Funeral** Hours 0771971948 DC 62 **Director** 219-54-7185 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 X No MD Calvert Owings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 2505 Kerry Ann Lane 20736 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important if item 27 is marked other than any injury or other trainmatic. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Pharmaceutical Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nora Dean Norman W. Mencer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27183 Whitelevsburg Road, Greensboro, MD 21639 William C. W. Mencer / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Epiphany Episcopal Cem. 05/04/2011 Forestville, MD 4 Donation 5 Other (Specify) m01533 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee m 8200 Jennifer Lane, Owings, MD 20736 Amanda M. Ergler complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Part 1. Enter the disease, or shock, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami executed Cause (Disease or linjury that initiated events physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death for Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown detached P.O. | signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Melanoma, Hypokalemia, Diarrhea 1 Tes 2 No 3 Probably 4 M Unknown Division of Vital Records, Completed page 2 should peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 X No 1 Yes 2 No after death.

Director; After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

LRW 20

Chuanbo Zhang

, M.D.

Registra

Holy Cross Hosp, tal, 1500 Forest Glen Rd, Silver Spring Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\mathbb{Z} \ \mathbb{U}$ For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) John Hershey McConnell Physician/ 01 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 110 8. Date of Birth
(Month, Day, Year)
Sept. 21, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. Pennsylvania **Funeral** Months Days Min. Hours 83 218-20-9425 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 🗌 Yes 2 🔀 No Federalsburg Caroline Mi) 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21632 Funeral 518 Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify Specify: White permit. Page 1 and 2 should be filed within 72 hours aft Department of Heatil hand Mehalt Hygheid. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any Injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Year or Dates. **'** 45 – 52 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Maryland State College (1-4 or 5+) Elementary/Seconday (0-12) Highway Administ. Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Kingan ၉ Duffrin McConnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 510 Liberty Rd. Federalsburg, MD 21632 James H. McConnell/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State Hurlock, Maryland June 2011 Veterans Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death Pregnant at time of death Month Day Year in the past 12 months? 5 Other (specify) 1 Yes 2 L 9 Unknown 2 🗌 No After this certificate has been signed by the a funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 death? 2 No 1 Yes 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28d. Describe how injury occurred 28a. Date of injury 28b. Time of 27. Manner of Deat 28c. Injury at Certificate: (Month, Day, work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M ☐ Accident ☐ Suicide Investigation Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatur 2 65656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 216

State Registrar

32. Regia rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $\underline{28}^{\text{Day}}$ Physician/ 2011 3:00 A M April Andris Neimanis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Dunkirk 2911 Cedarwood Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month Day, Hours Min. 1937 Country) 1 X M 2 🗆 I Latvia Yrs. 115-28-6469 74 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Tes 2 X No MD Calvert Dunkirk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20754 USA 2911 Cedarwood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Ď 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flight Surgeon College (1-4 or 5+) Elementary/Seconday (0-12) Dermatologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Neimanis Made Velta Bet Ludvigs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Birch Lakes Dr. Hawthorn Woods, IL Peter Neimanis / son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 29 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Lee Crematory Clinton, MD 2011 4 Donation 5 Other (Specify) Lee Funeral ilome Calvert, PA 22. Name and Address of Facility 21. Signature of Eneral Service Licensee Owings, MD 20736 8125 Southern Maryland Blvd Gary J. Goff Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ongestive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1000 Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed 1 🗌 Yes 2 🗆 No certificate 1 ☐ Yes 2 No 26. Place of Death (Check only one) or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 🗌 Yes After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural within 24 hours after death. To the Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the best of examination and instruction an Medical 29a. Certifier 2 In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of ge who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 2D rince Fred Maynon 31. Date filed Month, Day, Year) 32

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a per fh 9915 5-13-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Day 201 Tear Physician/ 8 8:00 pm^M Overs Susan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 6234 White Oak Drive Frederick 9. Birthplace (State or Foreign Country) Vermont Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov 11, Year) 923 **Funeral** Months Days Hours 1 □ M 2 🕱 F 112-14-4072 87 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6234 White Oak Drive 21701 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadar Judith Paul Bobro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6234 White Oak Drive, Frederick, Maryland 21701 Cameron Overs, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Elm Lawn Cemetery May 12,2011 Tonawanda, New York 4 Donation 5 Other (Specify) of Funeral Service License 21. Signatur 22 Kame and Address of Facility ord P.A. Funeral Home MQ0706 East Church St. Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ALDIO VASCULA DISEASE Immediate Cause (Final Theroscopero Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Days to for as a monarquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 ☐ No After this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2-No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and p Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D35152 May 8, 2011 2_{SPA} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180 Thomas Johnson Dr, Frederick, Maryland 21702-4489 James L. Krantz, M.D., 31. Date filed (Month, Day, 1 3 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>11</u> Physician/ Mary ratica MAY 7 8:00A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES CHARLES CO.NURS. & REHAB.CENTE LA PLATA Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months 93 Yrs. Hours 099-28-7826 Month, Day Year) 917 NEW YORK Director Usual Residence of Decedent filed within 72 hours after death with the Maryland all Hygiene.
d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1034 WILTSHIRE DRIVE 20646 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANTS WAITRESS 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ഉ FELIX COSTANZO CONCETTA CONCIDLERI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1034 WILTSHIRE DR. JACQUELINE BUDWEE-DAUGHTER LA PLATA, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TROPOLITAN CREMATORY Signature of Faneral Service Licenses 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final ongentive Physician/ disease or condition Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Ninknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COSONOUL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page **Director:** After this certificate I 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29d. Date signed (Month, Day, Year) 071199 07 2011

State Registrar inp, ron tidewater Colonypyine 1A, Annapolis MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

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2011

VERONICA PATRICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1215 PM **Physician** Hampton Dri 2011 Wade /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F 177-44-8984 58 Sept. 12, 1952 PA Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2204 Greenery Lane, Unit 201 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 25 Married Saltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 Yes 27 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mathematics Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wade Hampton Pugh, Jr. Dorothy Aberts မ 19a Informant's Name/Relationship (Type. Print) Lisa R. Pugh/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Greenery Lane, #201, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Faci Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of) **Physician** HRRES disease or condition resulting in death) /Medical Examiner VLSELESS ELECTRICAL ERSISTEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed NFERIOR and resulting in death) Last Due to (or as a consequence of) burial-P.O. Box 68760, physician by Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year ģ in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No the Unknown 9 🗍 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ate has been signe page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 1 ☐ Yes 2 ☐ No or Attending Physician: 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 3 🗆 DOA 1 Impatient 2 ER/Outpatient 5 Residence မ 27. Manner of Death 28a. Date of Injury Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title 7ES-000 A WUT

Registrar

State

BLANCO

's Signature

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B/VITRAGO

32 Registra

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29 2011

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Powell Rosle 30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Woodside Ce Silver Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or oreign **Funeral** Hours Months 0 77 1 0 / 1 M 2 T ່ 1 950 Director 410-86-1883 Tenn 60 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and tifene 23 or 28a-f show ant. If tiene 27 is marked other than "natural", or items 23a or 28a-f show ury or or wher traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🗷 No Montgomery 2501-E McVeary Court 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral Silver Spring 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) D.C. Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fannie Mae Lyons Woodrow Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2501-E McVeary Ct Silver Spring, MD 20906 Alprett Young sister permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 □ Cremation 3 □ Removal from State Silver Spring, MD 4/29/2011 Gate of Heaven 4 🗌 Donatigh 5 🗋 Other (Specif 22. Name and Address of Facility Signatur of Funeral Ser Philip Blvd. D. RinaldiFuneral Silver Spring, MD 9241 Columbia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a con • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial yansit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 4No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner - eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D. 0 Vultane H67624 30. Name and address of person who completed cause or death (Item 23a) (Type, Print) AFROOZ, Rol. Bel pring 31. Date filed (Month, Day, Year) Registrar's Signature State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RANDFORD 03/1 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center Arundel <u>Annapolis</u> Anne | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar 25) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1921 Maryland 1 □ M 2 □ 212-32-1693 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2670 Carver Rd. 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Black 3 XWidowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Housewife None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garfield Branford Hattie V. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Lippman(Daughter) 416 Morris Hill Ave Glen Burnie, Md. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State Maryland Veteran 5-3-11 Crownsville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Minama Reason Sacions Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Varry Approximate nterval Between Direct and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown itions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner Examiner

Important: If item 27 I any Injury or other tra

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me iteal Examiner must be notified at

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12 should be filed w h and Mental Hygier 7 Is marked other th

1 and 2 Health

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Baltimore, Maryland 21215-0036

burial-trar attending physician as the l ned by the a detached for signed by t

Physician/Medical

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Completed

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Certification:

Medical

certificate be executed

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Phys 4 hours after death. Funeral Director: After this completely filled in by the funeral

Par	t II. Oth	er sign	ificant c	

		1 Yes 2 No 1 Yes 2 No						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	flome 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1	(Month, Day Year) Injury Work?	3d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)						

2	9a. Certiner
	(Check only
	one)
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🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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bb. Signature and title of certifier Charl J Fentaw	29c. Lice	ense numbe	21

29d Date signed (Month, Day, Year) YUNDEYENSEHWY ANNAPOLL)

State Registrar ENTAM

To the Hospital of within 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APCI Physician/ 201 エヌHTヌ UJEEN **9** M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Glen Burnie Anne Hrunder Baltimore Washington Medicul Center
5. Social Security Number 16. Sex 17. Age (In yrs. last birthday) If Unc If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** 1 □ M 2**X** F Days May 22 Months Hours Year 940 Maryland 70 218-36-8192 Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Completed by Funeral 3 North Lane 21054 USA 1085 Rt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Engee. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Ò Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Oueen Samuel Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15622 North Platte Dr. Bowie, Md. 20716 David Queen(Son) Baltimore, 20b. Place of Disposition (Name of cemetery, erematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XI Burial 2 Cremation 3 Removal from State Memorial Church 4-29-11 Gambrills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windame Received & Cilisons Mortuary, P.A. . Signature of Funeral Service Licensee Lavy 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Priysician/ disease or condition resulting in death) 2740 Ol Medical Due to (or as a consequence of) Examiner 2440 PI TRACT NOITOSTAI PRAHIPIU Sequentially list conditions, if any, eaching to in a cause. Enter Underlying Cause (Disease or iinjury Due to tor Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No the 9 Unknown s been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown STROKE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh performed? Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after deam. he Funeral Director: After this ce neleted filled in by the funeral dire 2 X No 욘 1 Npatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 🗌

State

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29b. Signature and title of certifier

CUILLERMO JOSE 31. Date filed (Month, Day, Year) APR 2 8 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0065±14

301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161

29d. Date signed (Month, Day, Year)

1105 c 22 2 1994

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Do. (123 AM 04 27 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 👿 I 0171071947 Massachusetts Director 032-36-8190 64 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 11209 Oakwood Drive 20754 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 5 1 Never Married 2 Married چ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Yes, Give Specify: white "natural", 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) real estate should be filed with h and Mental Hyglen 7 is marked other th secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Albert Dedo Frances Tolman William 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Pennhouse Ave., Penn Wolverhampton, WV44BE, England Kerri L. Hughes, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Page 1 1 ☐ Burial 2 🖫 Cremation 3 ☐ Rerpoval from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/29/2011 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. ulure of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician scaro Medical resulting in death) Due to (or b a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: Exami requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and the attending physician shed for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 1 | Yes 2 No 9 | Unknown 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20061383 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address Prince Frederick, my 10 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24, 201rd 8:25 P Charles Philip Ranneberger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brunswick Frederick 52 Concord Drive 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Hours Oct. 8 Year 925 Mary Tand Director 85 217-32-5441 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Brunswick Maryland Frederick 10f. Zip Code 10e. Street and Number r items 23a or iner must be n P 10g. Citizen of What Country? Funeral United States 21716 52 Concord Drive within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian r than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Health and Mental Health 27 is marked ot မ Gladys Hickman Robert Conrad Ranneberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
52 Concord Drive, Brunswick, MD 21716 19a. Informant's Name/Relationship (Type, Print) Nancy Ranneberger / Wife permit. Page 1 and 2 Department of Health Important: If Item 2: any injury or other t other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/28/2011 Frederick, Maryland Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1100 North Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition V Cari Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Dire to or as a consequence of or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? Authy Discap 24a. Was an has autopsy After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 □ Yes 2 □ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Accident
Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 203

State

Registrar

egistrar's Signature

Green

BRUNSWICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kinland

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31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Genevieve Rosenthal 20^{Yea}r 1:46A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing Home Denton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign WeSt^{intr}Virginia **Funeral** 8 Date of Birth Months Days Hours Min. Juneth, Pag Year 1919 234-20-5966 Director 91 Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Caroline 1 X Yes 2 No Maryland Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143 Sunset Drive U.S.A. 21629 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Food service 12 H.S. Grad <u>Waitressing</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Clinton Fiske Ramsey Mamie Bell Legg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st ment of Health a tant: If item 27 is Margaret Arnold 143 Sunset Drive Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Hill Crest Cemetery May 4, 2011|Annapolis, Maryland 21. Signatur of Funeral Service Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Friysician/ Deme a. end 34000 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? perform this certificate 1 Yes 2 No 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manus of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 \square Pending thin 24 hours after death.

the Funeral Director: A propleted filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 20023922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2165 8~ Perston 3683 Cnost 53 Weling 31. Date filed (Month, Day, Year) State Registrar's Signa APR 28 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per th g915 5-13-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Arno Wayne Shingleton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Cumberland Allegheny If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jan 8, 9. Birthplace (State or Foreign Country) WV Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F 94 1917 Director 579-07-9225 Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director WV Hampshire Romney 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral HC 63 Box 2580 26757 USA items 12. Was Decedent Ever in U.S. Armed Forces? 14. Yes 2 1941-44 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examins ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile 12th Auto body repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Edward Shingleton Clersia Viola Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, TX 78620-3903 504 Bending Oak Dr., Dripping Springs, Dennis A. Shingleton 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔲 Removal from State Indian Mound Cemetery 5-11-11 4 Donation 5 Other Specify) Romney, WV 21. Signature of Funeral Service 22. Name and Address of Facility Shaffer Funeral Home, Inc. 100 230 E. Main ST., Romney, WV 26757 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine or as a consequence of) resulting in death) Last burial-1 attending physiclan for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? arten eisease 24a. Was an has performe 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) illowbrook Rd State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Joyce Α. Seaberg 1:05 P M 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park 518 Lakeland Road South 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours Min. 1 □ M 2 🖫 F 470-32-1346 78 Minnesota Director Sept. 16. 1932 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Severna Park with the Maryland 10d. Inside City Limits notified at Director Anne Arundel MD 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? traumatic event, the Medical Examiner must be 23a Funeral USA 518 Lakeland Road South 21146 items ? within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Bookkeeper and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Goldie Young John F. Hanzalik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Taplow Road Baltimore, MD 21212 Erin Somers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 27, cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State Metro Crematory, INC. 4 Donation 5 Other (Specify) Baltimore, MD 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Exter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MUCCE disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iirijury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day 5 Other (specify) Year Pregnant at time of death s been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available page 2 s autopsy performed prior to completion of cause of death?

1 Yes 2 No After this certificate has Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? iniury 5 Pending death. Accident Investigation 24 hours after death Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only on the 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 4 MUV. GONT WO cause of death (Item 23a) (Type, Prin 30. Name and address of person

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31. Date filed (Mon

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32 Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04/24/2011 FREDERICK L. SNOWDEN, JR. 6:10 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Clinton Nursing and Rehab Clinton . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign DC Country) Days 1 X M 2 □ F Hours 10/28/1937 577-50-2719 Director 73 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 XYes 2 ☐ No MD Prince George's Clinton 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 9211 Stuart Lane 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 9 1 Never Married 2 Married 1X Yes 2 No 1961-If Yes, Give ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "naturaf", Completed 3 Widowed 4 Divorced 1963 Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than " United States College (1-4 or 5+) Elementary/Seconday (0-12) Postal Service <u>Baqqaqe Handler</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick L. Snowden, Sr. Evelyn K. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne S. Jones/sister 5100 New Hampshire Avenue, NW, Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place 12 Burial ☐ Cremation 3 ☐ Removal from State George Washington Cm 05/03/11 n 5 Other (Specify) Adelphi, MD 21. Signatur A neral Service Lic-use 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or comp shock, or heart failure. Just only of he that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complica Approximate Interval Between Immediate Cause (Final Onset and Death Pitysician) Hypertensive cardiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to increase cause. Enter Underlying Examine Due to (or as a nonsequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last **burial** attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Unknown signed by the a Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? certificate 1 🗌 Yes 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 X No မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) 29c. License number 04/26/2011 D52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Musa Mark Momoh

APR

29 2011

31. Date filed (Month, Day, Year,

1386 Southern Avenue, SE, Washington, DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 5:00 P BRUCE ALDEN SOMERS APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 X M 2 🗆 F MASSACHUSETTS Director MARCH 6, 137-40-3160 61 1950 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director 1X Yes 2 ☐ No MD KENT CHESTERTOWN ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 225 DEVON DRIVE 21620 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner Armed Forces JO. Completed by 1 Never Married 2X Married 1 X Yes 2 No Maryland 21215-0036 1 Yes 2X No Specify: Yes Give "natural", Specify: 3 Widowed 4 Divorced WHITE Year or Dates. 1969-73 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 SELF EMPLOYED / PART OWNER AUTOMOTIVE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MYLES E. SOMERS MARGARET S. WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health SHARON SOMERS / WIFE 225 DEVON DRIVE CHESTERTOWN. MARYLAND 21620 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 04/19/2011 STEVENSVILLE, MD Signature of Funeral Service Licen 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 30 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complication that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer Immediate Cause (Final Squanaus Cell Careinony Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burial-t attending physician for use as the burial Physician/Medical certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day 9 Unknown 9 Unknown ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Modiustimal Muss with metastives to bove, lymphatics, liver. BPH, columne Intolerance 9 Records, 3 Probably 4 Unknown Completed 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 🗌 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director; After the leted filled in by the funera 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Dis completed filled in Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 5+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 7:00 A M MARY CATHERINE SEIDEL APRIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death KENT ROCK HALL 21915 SCOTTS DRIVE **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 □ M 2 **X** F Hours MAY 6, MARYLAND Director 213-24-4350 1926 Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No KENT ROCK HALL MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21915 SCOTTS DRIVE UNITED STATES 21661 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ MARY ELIZABETH FREEMAN GILBERT LARRIMORE ASHLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET NORDHOFF/DAUGHTER IN LAW 21349 ALLENS LANE ROCK HALL, MARYLAND 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WESLEY CHAPEL CEMETERY 04/20/11 ROCK HALL, MARYLAND 21. Signature of Funeral Se 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 23a. Pal. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shill k, or heart failure. List only one lause on each line. Approximate Interval Between END Immediate Cause (Final DEMENTIA Physician/ S TA68 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed burial-transi Due to (or as a consequence of) Physician/Medical 68760 88 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 No has prior to completion of cause of death? certificate ☐ Yes 1 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes မ 2 A No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Division within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 of certifie 01-1 Name and address of person who completed cause of death (Item 23a) (Type, Print) Tm

DHMH 17 Rev 7/2009

State Registrar

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Medical Examiner		resulting in death)		Due to (d	or as a conse	quence of	f):							-			
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hysic this c	ပ္	1 Yes 2 XNo	Hos		npatient 2 [3 🗆 DO	A Other	". 4□ N	lursing Ho	ome 5 Resi	dence	6 Other	(Specif	y)	
nding Fath. r: After e funer	icate	27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	ding stigation	28a. Date o (Month	h, Day, Year)	28b. Tii inj	me of jury	M 28	c. Injury work? 1 \Bar Y		No	28d. Describe	how inj	ury occurred	d		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hereta distra death. To the Funeral birector: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certificate	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be rmined	28e. Place o buildin	of Injury - At g, etc. (Spec	home, farr	m, street,	, factory,	office			28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,	
spital neral l		29a. Certifier 1 Certify	ng Physici	an: To the be	est of my kno	wledge, de	eath occ	ured at t	he time.	date and	place, ar	nd due to the ca	ause(s)	and manner	as stat	ed.	
the Ho hin 24 I the Fu	Medical	only one) 3 Certify	ng Nurse F	r: On the basis	s of examinat	ion and/or	investiga	tion, in m th occum	y opinion ed at the	time, dat	occurred a	t the time, date ce, and due to the	and pla	ce, and due:	to the ca	ause(s) and man	nner stated.
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Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

MAY - 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 201^{Year} Shirlev Mae Smith 26 12:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛣 Maryland 01-08-1939 Director 215-38-2557 72 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 85 Hospital Road 20678 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian Armed Forces? 0 Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Specify. Year or Dates white oth and Mental Hygiene.
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1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year g Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus -1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cerebrovascular Accident 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has performed? Yes 2 No Arterial direase Periphenal 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospira. ... n 24 hours after death. he Funeral Director: Aft 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) yon c. surono. D-50653 4-26-2011 GYAN C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muschton Deale Road Deale miD 20757 31. Date filed (Month, Day, Year) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 5527 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav 2011 9 Marian Α. Tisdale 6:05 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Buckingham's Choice Frederick Adamstown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 💢 F Months Davs (Month, Day, Year) 07/08/1913 Country) Missouri Yrs. **Director** 97 39**1-**12**-**2818 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Frederick 1 Yes 2 No MD Adamstown 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3200 Bakers Circle. Apt. A-213 21710 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 💢 No 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 😾 No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify: white Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ education professor other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John H. Atkinson Elvira Newby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 John Tisdale 308 Grove Blvd., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. 70 Page 1 1 ☐ Burial 2 🏹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/10/2011 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home arrelle the MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Failure to Thrive Medical Due to (or as a consequence of) Examiner 1-2 davs Dehydration Sequentially list conditions if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) Examir and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page ; perform 2 🗌 No Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work death. 1 ☐ Yes 2 ☐ No Accident Investigation Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a, Certifie 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one and title of 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) 5/09/2011 H0070147 Digi SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thaker 1502 S. Main St., Mt. Airy State MAY 1 3 2011

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State Registrar 31. Date filed (Mo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:06 PM Inomas 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Medical cente of Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 218 – 24 – 5909 (Month, Day, Year) ay 13, 1929 1 M 2 KF 81 **Director** May Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Preston Caroline 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21655 4808 Frazier Neck Road United States ould be filed within 72 hours after death vind Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **2+** Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Wesley Friend Viola Lovinia Carrie Simpson 1 and 2 should the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4803 Frazier Neck Rd., Preston, MD 21655 Donald P. Thomas/Son permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cem. Preston, Maryland 05/07/11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line gastrointestina Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner negativ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin that the death certificate be executed burial-transi Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes To the Hospital or Attending Physician: nin 24 hours after death.

the Funeral Director: After this certific
pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 1043445976 April 29,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YN8 S. Greene St. Baltimore, MD 2120 Eleanor MI Hutchens, 22

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRTT. MARJORIE R VANSANT 2011 9:03P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 20 6. Sex 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 🖾 F Months Hours Maryland 87 Yrs. **Director** 219-20-1270 June 1923Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location must be notified at 10d, Inside City Limits Director 1 X Yes 2 No Maryland Carrol1 Mt. Airy 0 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 1009 North Main Street 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ŏ p 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene. 77 is marked other than "r Van Sant Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumbing & Heat Inc. Bookeeper traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Guy A. Robinson Elsie Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Larry Van Sant/ Son 3320 Heavenly Cause Court, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any Injury or Pine Grove Cemetery 4/28/2011 Mt. Airy, Maryland. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Serv 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List day one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year the 1 ☐ Yes ∠ ■ 9 ☐ Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page, performed? Yes 2 No 1 Yes 2 No funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2X No ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA this (4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Within 24 hours after weave.

To the Funeral Director: After Certificate: 28c, Injury at work? 28d. Describe how injury occurred Hospital or Attending 1X Natural (Month, Day, Year) 5 Pending 2 Accident 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 4/25/2011 MDH 64135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Safrina 7th St Frederick Hasan

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State Registrar

Box 68760

P.O.

Records,

Division of Vital

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY Month 2019 VERA NELL WATSON 7:45P М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 47 MEADOW LANE WALDORF 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** SEP 9 Days Hours 1 🗆 M 2 🔀 F 84 Yrs. N.CAROLINA 577-34-6452 1926 Director Usual Residence of Decedent f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho , the Me ic ∗l Examiner must be notified at Director 1 Yes 2 No MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47 MEADOW LANE 20601 U. S. A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc ð 1 Never Married 2 Married 1 Yes 2X XNc Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene. College (1-4 or 5+) within Elementary/Seconday (0-12) WAITRESS RESTAURANT be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY VERNON CARVER MACTE BELLE SAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMMY KLINE/DAUGHTER MEADOW LANE WALDORF, MARYLAND 20601 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State TRINITY MEM.GRDNS: 17,2011 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. ora M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not en the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical law requires that the death certificate be Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 275 s been signed by the sign should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Inknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy perform Hospital or Attending Physician: The After this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No s after dea... ral Director, Aftr 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation To the Hospital or Atterwithin 24 hours after der To the Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) son who of death (Item 23a) (Type, Print completed cats ATHER

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Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#7,8 per FH State of Maryland / State of Maryland / Registrar 4/28/2011 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 0 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** <u>1504 LINCOLN BLVD</u> <u>SEVERN</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 8/4/1969 **Funeral** 1 Ø M 2 □ F Months Days Hours Min Director - 41 544-82-4606 Usual Residence of Decedent Addition of the state of the st 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director MARYLAND ANNE ARUNDEL SEVERN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1504 LINCOLN BLVD 21144 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ģ 1 Never Married 2 Married 2 🗆 N Baltimore, Maryland 21215-0036 1388 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) ANALYST Be . Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked otl 17. Father's Name (First, Middle, Last) ALAN RUSSELL WALDRAM, SR. 19a. Informant's Name/Relationship (Type, Print) REBECCA WALDRAM/WIFE 1504 LINCOLN BLVD, SEVERN, item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE VETERANS 4 ☐ Donation 5 ☐ Other (Specify) 05/03/2011 21. Signature of Funeral Service Lin 22. Name and Address of Facility T HELFENBEIN & NEW 23a Part 1. Enter the diseas shock, or heart failure se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician/ BRAIN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be Records, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural or Attending 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Hospital 24 hours Funeral Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this political, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Type, Print) ENTA ICHAIL 31. Date filed (Month, Day, Year) State

GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) KRISTINE ANN HULTQUIST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21144 20c. Location - City or Town, State Approximate nterval Betweer Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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IDAHO

14. Race - American Indian,

WHITE

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 XNo

4c. County of Death

 $\underline{\mathsf{ANNE}}$

USA

Specify:

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Day 2011 12:09 PM 26, APRIL MILDRED OLGA WESSEI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN NURSING & REHABILITATION CHESTERTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months (Month, Day, Year) L**0/02/1916** 94 MARYLAND Director 217-07-6021 Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No WORTON MARYLAND KENT 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 25840 WORTON-LYNCH ROAD 21678 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc þ 1 Never Married 2 Married 2 **X** No Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) AGRICULTURE 12 BOOKKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ AMELIA ALMA FLORSTEDT GEORGE HERBERT SIMON, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25840 WORTON-LYNCH ROAD WORTON, MARYLAND 21678 RONALD WESSEL / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FULTON, MARYLAND ST. PAULS LUTHERAN 4/29/11 S nature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause in each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Exdrovascular Disease ten'o Priysician disease or condition resulting in death) Oyear? Medical Due to (or as a consequence of) Examiner Sequentially list conditions ray, leading to infriedate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform nis certificate ha 1 Yes 2 No 1 Yes 2 1No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in

State Registrar

Medical

29a. Certifier

(Check

only one

31. Date filed (Month, D

29b. Signature and title of certifie

Susink. Ress,

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Regi

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1)0017036

516 Washington Are. Chestorton Md. 21620

29d. Date signed (Month, Day, Year) 26/11

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 25 2011 2:30 P M Betty J. Williams Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Solomons Health Care Solomons Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days May 22 1925 1 🗆 M 2 🖵 F 85 Connecticut 013-22-2880 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Calvert 1 Yes 2 No Solomons 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 401 Epworth Ct 524 20688 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Sarah Pauline Dustin James C. Hatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Epworth Ct. 524 Solomons, MD 20688 John W. Williams Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr 12 28 2011 20c. Location - City or Town, State permit. Page 1
Department of
Important: If i
any injury or c 1 Burial 2 Cremation 3 Removal from State Alexandria Virginia Metropolitan Funeral Service 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Multivalvular Heart Disease Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease, Chronic 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Obstructive Pulmonary Disease 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Legitifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wey D26358 April 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jew 20 John H. Weigel, MD Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature parket 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:15 PM Physician /Medical Lyons WILKINS APRIL CLYDE 24 2011 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Aug. 29, 1 5. Social Security Number Age (In yrs. last birthday) Days **Funeral** 1 XM 2 ☐ F 86 189-18-2433 Aug. 1924 Delaware Director Usual Residence of Decedent ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mential Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Milford DE Sussex Director or other traumatic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10f. Zin-Code 10e. Street and Number 19963 308 Hall Place Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 X Yes 2 □ No
If Yes, Give 43-46
Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Govt Mail Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosella Lyons Henry W Wilkins is marked မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 308 Hall Place, Milford, DE 19963 Audie M Wilkins 20c. Location - City or Town, State 20b. Place of Disposition (Name of Pages 1 20a Method of Disposition First State Cremation 5/2/11 1 Burial 2 X Cremation 3 Removal from State Millsboro, DE permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Center 22. Name and Address of Facility
Rogers Funeral Home Inc 21. Signature of Funeral Service Licensee 301 Lakeview Ave., Milford, DE 19963 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Dilated Cardionus of Due to (or as a consequence of). **Physician** /Medical **Examiner** Coreing anty discrite Sequentially list conditions, if any, learning to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed use as the burial-trar resulting in death) Last Due to (or as a consequence of): signed by the attending physiciar Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Vinpatient Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 2 No 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) 1 Yes မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division or Attending 1 Natural Injury 5 Pending 1 🗌 Yes investigation 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide determined 4 🗌 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

State

KAUSTUBHA

31. Date filed (Month, Day, Year)

, MD

32. Registrar's Signature

PATIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/lichael Wolfe	State of Maryland 1-For State Registrar	/ Department of Certificate of	Health and Mental H Death	-	2011	15536	
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last) Michael Lee Wolfe	2. Date of Death Month May 5, 201	Day Year	3. Time of Death 1710 hrs			
,	4a. Facility Name (if not institution, give street and number	2)	b. City, Town, or Location of Deat		4c. County of Death		
	University Hospital STU		Baltimore	lo ô · · · · · · · · · ·			
Funeral Director	045 04 0000	ge (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir		f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Pa.		
	215-64-0679 1 M 2 F Usual Residence of Decedent	55 Yrs.		April 11,1956 Country) Pa.			
Aue A	10a. State 10b. County	10c. City, Town or Locati				10d. Inside City Limits	
faryland 28a-f show Latonce. ector	Md. Frederick	Myersv		- 1:0		1 Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once.	12844 Stottlemyer Rd.		10f. Zip Code 21773	10	g. Citizen of What Coun	try?	
r death with the Maryland or items 23a or 28a-f sh c must be notified at once Funeral Director	11. Marital Status 12. Was Deceden		s Decedent of Hispanic Origin? (S		U.S.A 14. Race - Americ	can Indian, Black,	
death or iten must k	1 Never Married 2 Married Armed Forces 1 Yes 2	? If Ye	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	• •	
aral",	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade continuous) 15. Decedent's Education (Specify only highest grade continuous)	^ 1	Yes 2 No specify: 's Usual Occupation (Give kind of	work done	Specify: WN 16b. Kind of Business/Ir	ite	
12 hours	Elementary/Secondary (0-12) College (1-4 or	during mo	ost of working life. DO NOT use ret				
15-0036 filed within 12 hours after death with the Maryland I Hygiene. ad other than "natural", or items 23a or 28a-fahe t, the Medical Examiner must be notified at once © Completed by Funeral Director	12	EI	ectrician ————————————————————————————————————		Electr	1 Ca í	
ID 21215-0036 should be filed within 72 hours af and Mental Hygiene. 77 is marked other than "natural natic event, the Medical Examin To Be Completed by	17. Father's Name (First, Middle, Last) Elvin T. Wolfe			e (First, Middle, Ma M. Warre			
	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number or	Rural Route Numb	oer, City or Town, State,		
nore, MD 2 ages 1 and 2 shou ant of Health and It. Hiteus 12: to ther traumatic	Tina M. Wolfe (Wife)		Stottlemyer Rd.		11e,Md. 21		
	1 Neurod of Disposition 1 Neurod of Disposition 2 Cremation 3 Removal from St			y 10,	Garfield		
Baltimo permit. Page Department (Important: injury or ott	4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee	<u> </u>	Church Cem 2 ame and Address of Facility	2011			
Department in	Jelle Davis	M01414 J.		Home Sm	2525 Bradbu nithsburg.M	ry Ave. d.21783	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter th	e mode of dying, such as cardiac o	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
≟xaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a const					Death	
	Sequentially list conditions, b						
niner	if any, leading to immediate cause. Enter Underlying Cause	equence of);					
ted I Insit Examiner	(Disease or injury that initiated events resulting in death) Last	equence of):					
50, te be executed ysician and burial - transit	d. UNPENDED AMENDED						
'60, ate be a physicia buria Medi	IF FEMALE: 23c. If yes, outco	me of pregnancy			23d. Date of delivery		
6876 certificate nding phy ise as the b	23b. Was decedent pregnant in the past 12 months?	time of death	al death 3 Ectopic pregna	ancy	Month D	ay Year	
). Box 6876 the death certificate by the attending phy ched for use as the V Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	ottime or death 5 Oth	er (Specify)				
cords, P.O. Box 6876 law requires that the death certificat has been signed by the attending ph 2 should be detached for use as the repleted by Physician/M	Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause given in Part I.		acco use contribute to t		
Records, P.(: The law requires that fifcate has been signed to page 2 should be det. Completed by				24a. Was ar	2 ✓ No 3 Prob	opsy findings available	
COFC				autopsy perform	prior to co	ompletion of cause of	
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical		26.Place of Death (Check	1 ✓ Yes 2	No 1 ✓ Yes	2 No	
Vital hysician: hysician: this certical director	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatie	ent 2 ER/Outpatient	100-		esidence 6 Other:	-	
Division of Vital Records, rat or Attending Physician: The law requirers after death. The Director: After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death 1 Natural 5 Pending May 3, 2011	ury 28b. Time of In (ear) 1428 hrs			ow injury occurred notorcycle involve	d in collision with	
Sior Attend r death ector: by the	2 Accident Investigation		1 Yes 2 ✓ No	vehicle	reet and Number or Run	al Poute Number City	
Division o spital or Attending hours after death. Heart Director: After the function of filled in by the function: Certification:	Suicide 6 Could not be	ijor Road / Highway	t, ractory, office ballang, etc.	or Town, Sta			
9 4 5 5 1 1 29a (eruller 1 1 2							
To the B. within 24 To the Fr. completel	one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	mination and/or investigati	on, in my opinion, death occurred a				
2	23b. Signature and time of certifier		O.C.M.E.		29d. Date signed (Mon May 6, 2011	ш, <i>บ</i> ау, теаг)	
	30. Name and address of person who completed cause of c	leath (Item 23a)			, , ==		
	Donna M. Vincenti, MD Assistant Medic	cal Examiner 900	W. Baltimore Street, Baltin	nore, MD 212	23		
State Registrar	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 201^{Year} 12:43Pm Lewis Joseph Yedinak, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 El kton Union Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/01/1949 **Funeral** 9. Birthplace (State or Foreign Months Hours 1 X M 2 | F 216-48-2919 Director 62 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Ceci1 E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 441 Rock Church Road 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 Yes 2 X No White 3 Widowed 4 Divorced Specify: Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Merical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Undercutter Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Demond Henry Yedinak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Yedinak / Wife 441 Rock Church Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Immaculate Conception: 05/05/2011 4 Donation 5 Other (Specify) E1kton, MD 21. Signature of Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Hysician) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any heading to immediate cause. Enter Underlying Examine naequence that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical E FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death ed by the 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Hospital or Attending Physician: The law requires 2 No Completed 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗌 Yes 뎯 2 **N**No 1 Ninpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15538 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Joyce K. Armstrong May 10:28 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Cent Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan 22, 9. Birthplace (State or Foreign Country) North Dakota **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 😾 F Months Days Hours. Director 214-24-1821 Yrs Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 Chestnut Avenue #1416 21204 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: white Maryland 21215-00(Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Monroe Joseph Kirk Edna Baird of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hart/daughter 542 Piccadilly Road Towson, MD 21204 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) El neral ervice Licen na Id Sa Wad State Anatomy Board 655 W. Baltimore Street MD 23a. Aart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as consequence of attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate l Yes 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) 2 000 မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending ours after death.

neral Director: A
filled in by the fi 1 Yes 2 No Investigation 6 Could not be Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie WILLY THE THE PARTY OF THE PART

Registrar

State

WALTER

completed cause of death (Item 23a) (Type, Print)

MD

HETTINGER

D19853

6701 N. CHARALES ST

MAY 8,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 15539 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 10 Day 201 Tar GERALDINE J. BURKOWSKI 9:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE 400 FRANKLIN AVENUE ESSEX Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 AF Months Days Hours Min DCTT#7Day1938 MARYŽAND Director 216-36-5461 72 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. BALTIMORE **ESSEX** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 66 WILTSHIRE ROAD 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) RIVERVIEW College (1-4 or 5+) 2 YRS Elementary/Seconday (0-12) 1 2 T H ADMINISTRATIVE NURSING HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH JAWORSKI GENEVIEVE MAZAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BURKOWSKI SON SOLOMONS CROSSING MILLERSVILLE, MD21108 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY ROSARY CEM. 1X Burial 2 Cremation 3 Removal from State 5/14/2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility ACZOROWSKI FUNERAL HOME, PA DUNDALK 201 <u>AVENUE BALTIMORE</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between enal and Sigmod Onset an Ceath Immediate Cause (Final Physician/ Hollonle disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f 9 🔲 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

• Funeral Director, After this certificate has be funeral director, page 2 t autopsy performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 X No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mapner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of certifier N D D 38754 MAY 12, 2011

DHMH 17 Rev 7/2009

State Registrar EASTERN BLVD.

BALTIMORE

709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASEEM, M.D.

MALIKA

31. Date filed (Month, Day, Year)

F.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Year 2011 300 M STARLENE Medical BROWN 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Franklin Square
5. Social Security Number 16 Rosedale Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day, Year) 1956 1 □ M 2**X** F Months Days Hours Min. **Director** APRIL 218-64-0587 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f XX Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be r Funeral 2719 W. BELVEDERE AVENUE 21215 USA items 2 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter edical Examiner Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed 3 Divorced 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 COUNSELOR WIN FAMILY SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM GALLOWAY FRANCES BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. <u>JEAN OLIVER/SISTER</u> 3615 KENYON AVE. BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MT. ZION CEMETERY 5-21-2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a cons- uence of) **Examiner** DS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Pneumon Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exeruithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician a physician at the burial Physician/Medical Difficile Colitis Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Year Day Pregnant at time of death g Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural iniury 5 Pending 2 🗆 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one

State Registrar

29b. Signature ar

Brown

ung AD 9000 Franklin

erson who completed cause of death (Item 23a) (Type, Print)

29c. License number

736

29d. Date signed (Month, Day, Year)

12011

5

110

ware Drive, Baltimore MD, 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Allen D. Brumbaugh 2011 4:50 12 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Charlestown Care Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠** M 2□ F 14, 1920 North Dakota 90 Nov. 501-12-5712 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Exacting must be multiled any Injury or other traumatic event, Ite Modical Exacting must be multiled and ponce. 1 ☐ Yes 2 X No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 IISA 6207 Wild Swan Way Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 TXYes 2 No
If Yes, Give
Year or Dates:1941-60 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Specify. 2 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Technician U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David O. Brumbaugh Mary June Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6207 Wild Swan Way; Columbia, MD 21045 Melodie Hearne Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto-Wash.Crematory | 5/16/2011 |Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lic 1630 Edmondson Avenue: Catonsville 21228 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears Physician Alzheimer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe certificate 1 ☐Yes 2 No 1 Yes this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2☑No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 Accident 5 ☐ Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 OHIV ress of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Ln Catonsville MD MD corporter 32. Registrar's Signature MAY 16 2011 State Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene											
			For State Registrar	State of Ma	•	epartment of I Certificate of			eg. No. 2 N	1 1551.2	
			Registrar Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death	
	Physicia /Medic		Buby Barlou	0				May	7 2011	2:30PM	
9	Examin	er	4a. Facility Name (If not institution, give st	treet and number)	0.0	4b. City, Town,	or Location of Death	,	4c. County of D	eath More	
	Funeral		5. Social Security Number 6. Sex	Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) $1 \square M$ 2 $1 \square M$ 3 1							
	Director		XX5-30-94/9	M 2 XF	86 Y	rs. Months Days	Hours Will.	JAN.	30, 1925	Country)	
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	a-fsh	ctor	MD 139 LTC	5,	Tou	SON				1 Pres 2 No	
	vith the	Director	10e. Street and Number	7.		10f. Zip Code		1	Og. Citizen of What	Country?	
	ns 23g	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - A	merican Indian,	
9	after d or iten		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	•	If Yes, specify Cul 1 ☐ Yes 2 ☑ No	ban, Mexican, Puert	o Rican, etc.)	Black, W		
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Everimer rust be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:	10-				Specify:	WHITE	
15-	in 72 ł n "nat	plete	15. Decedent's Education (Specify only highest grade	completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of wor	king	16b. Kind of Busine		
2121	be filed within 72 hours after death with the Marylan tial Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Middel Evacine must be notified.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	' <i>F</i>	lomen	AKER		OWN	HOME	
and	hould be filed nd Mental Hygi marked other matic event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)		
Maryland		오	19a. Informant's Name/Relationship (Typ	pe. Print)	19b.	Mailing Address (Stree	et and Number or Ru	iral Route Numbe	r, City or Town, Stat	re, Zip Code) 1 2 0 4/	
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ore	ges 1 and to f Heal		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place of cemeters	Disposition (Name of crematory or other plants	ace)	Date	20c. Location - City		
altimore	permit. Pages 'Department of H Important: If ite any Injury or of		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		MT.	CARME 22. Name and Add		2-11	BALTO.	100.	
Ba	permi Depar Impor any Ir		Them so I a	Skar do	2.	SKARDE	F.H. 2	3570 L	HUPSON :	21224	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused le cause on each lin	the death. Do n	ot enter the mode of dy	ving, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
-	Physician		Immediate Cause (Final disease or condition resulting in death)	Conge	stive	Heart Fa	ilure			Syears	
-	/Medical Examiner			Due to (or als a	consequence o	f):				RUPIK	
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o		87003				
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	. Demo	consequence of		8 years				
760,	rificate be executed in physician and as the burial-transit		L _a	d							
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical									
Вох	eath cer attendin for use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Fetal death	3 Ectopic pregnar	23d. Date of Month	delivery Day Year			
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify)					
ر. ح.	res that signed b be deta	by Pr	Part II. Other significant conditions con-	ntributing to death bu	t not resulting in	the underlying cause g	given in Part I.	23e. Did to	obacco use contribu	te to the cause of death?	
ord	w require been sign							1 D Y	/es 2. 12 No 3. □	Probably 4 Unknown	
3ec	: The law cate has b page 2 sh	Completed						24a. Was autop	an 24b. Wer prior rmed?// dear	e autopsy findings available r to completion of cause of h?	
Vital Records,			25. Was case referred to medical				26 Place of De	1 □Yes	2 □ /No 1 □	Yes 2 □No	
of Vi	ysic is ce direc	To Be	examiner?	lospital: 1 ☐ Inpatie	nt 2 ER/Ou	tpatient 3 DOA	thor: 4		dence 6 ☐ Other (Specify)	
	ng ffel	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	y (Year) 28b. T	ime of 28c. In		28d. Describe h	now injury occurred		
Division	Attend death ctor: /	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	M 1 □Yes 2 □No					Location (Street and Number or Rural Route Number,		
Ρ	s after s after al Dire	Certification:	4 Homicide determined	building, etc	(Specify)			City or Tov	vn, State)		
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune			ner: On the basis of	examination an	, death occurred at the d/or investigation, in my					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of certifier	and manner sta	neu.	29c. Lice	nse number		29d. Date signed (A	fonth, Day, Year)	
	> - 0		· Marquitale	Snewn, (RIVE	RI	77248		May 10.	2011	
Y	/		30. Name and address of berson who con	ompleted cause of d	eath (Item 23a) (Type, Print)	De:100 1	=111=2	ne MAD -	1005	
	Sta	ite	31. Date filed (Wonth, Day, Year)	32. Registra	ar's Signature	MSIMICE	41100	1-1-11C	ye print		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 1, Year **Physician** 201^y1 John K. Bergen /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kent 24440 Smithville Road Worton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 18, 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**∑** M 2□ F Director 058-20-7278 84 1927 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f shov or other traumatic event, the Medical Examiner must be notified at Director MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Madical Exemples 200. 24440 Smithville Road 21678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 MYes 2 □ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by 3 Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John K. Bergen Helen Gertrude Moddle ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24440 Smithville Road Worton, MD Clara Bergen/spouse 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Sen 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the dis. ase, a populations that caused the death. shock, a leart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ has been si e 2 should t 2 / No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? page certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only she) Other: 4 \(\sum \) Nursing Home 1 Inpatient After this Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manor of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation I Director: And in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

and manner stated.

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7:30 AM M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

Year

white

1 ☐ Yes 2 ☐ No

within 24 hours a

State Registrar

Medical

29a, Certifier

(Check on

296. Signature and title of certifie

31. Date filed (Month, Day,

Name and address of person who

Year,

6

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Mar		partment of						
			1 - State Registrar Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death							++-	3. Time of Death 4	
	Physicia Medic		Paul Berr	nan			Month MC. S	Day	Year	7:00 4 M		
	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cou								0	
-d			Hovers Count, Ge-	neral	Hospite 1		I Killedor Od Hro	1000 (0)	140	200		
	Funeral Director		5. Social Security Number 6. Sex 122–20–3162	1 2 □ F 7. Age (II	n yrs.¶ast birthda 82 Yrs	Months Days	Hours Min.	8. Date of Bird Aug 30	y, Year) 1928	9. Birth	place (State or Foreign Itn) York	
	_		Usual Residence of Decedent									
	yland -f shc ed at	ctor	10a. State 10b. County	11	0c. City, Town or					1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ne Mau nr 28a notifí	Dire	MD Howard 10e. Street and Number		Woo	odstock 10f. Zip Code			10g. Citizen of	What Cour	21	
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Me Tical Ex-miner must be notified at	Funeral Director	11130 Chambers Cou	rt #J		1.011.21.10	21163		US.		,,,,,	
	items items	Fun		Was Decedent Eve Armed Forces?	r in U.S. 1	3. Was Decedent of H	Hispanic Origin? (Spann, Mexican, Puerto			e - Americ		
36	after c	i by	1 Never Married 2 X Married	1 ☐ Yes 2 X No If Yes, Give	,	1 ☐ Yes 2 😿 No		Thousi, otoly	Specify	ck, White, white		
ဝို	nours latura ical E	Completed	15. Decedent's Educa	Year or Dates.	16a. De	cedent's Usual Occu	pation		16b. Kind of B			
215	n 72 h e. tan "n	duc		only highest grade completed) (Give kind of work done during most of working						Tob. Nina of Business industry		
7	d withir ygiene her tha	Be C	12	2		self empl	 	<u>-</u>	photo		ner	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me Ical Ex-miner must be notified at	To B	17. Father's Name (First, Middle, Last) Jacob Berman				18. Mother's Nam Ye1	ne <i>(First, Middle,</i> tta Vosl		e)		
ary.	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relationship (Type, i	Print)	19b. M	ailing Address (Street	and Number or Run	al Route Numbe	r, City or Town, S	State, Zip (Code)	
	id 2 sh salth a n 27 is er trai		Joan Berman/spouse			30 Chamber					1163	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren		20b. Place of Di cemetery, o	sposition (Name of crematory or other pla	ce)	Date	20c. Location	- City or To	own, State	
턡	t. Page 1 rtment of 1 rtant: If it njury or o		4 X Donation 5 Other (Specify)									
Ba	permit. Page Department of Important: If any injury or once.		21. Signatur of a regal Service Licenses National Service Licenses		For	28 Name and Address Baltimore	•		. Balti	more	Street	
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	tions that caused th	e death. Do not				rest,	-	Approximate Interval Between	
-	nysician <i>i</i>	1 18	Immediate Sause (Final disease or condition	B-Cell	14-	home					Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a co	ons av nce							
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):					-		
	rted d ansit	Examiner	Cause (Disease or linjury									
	execu ian an	EX	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):							
09	ate be executed physician and the burial-transit	edical	d				<u> </u>					
687	certific iding p	/Me		If yes, outcome of					23d Da	ate of deliv	rerv	
30X	eath c atten d for u	Completed by Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregnant at til		3 🗌 Ectopic pregnar 5 🗎 Other (spec <i>ify)</i> _	cy			onth	Day Year	
O.	t the d by the tacher	Phys	9 🗆 Unknown	9 Unknown								
σ.	es tha signed be de	i by	Part II. Other significant conditions contrib		-						he cause of death? bably 4 Unknown	
Sta	requir been s should	letec	Coronary Adeny	6	0	:		24a. Was			ppsy findings available	
ecc	e has	duuo	convery Hotery	Sisese,	raesm	ي اس		perio	osy ormed?		mpletion of cause of	
a H	ian: Th	Be C	25. Was case referred to medical examiner?			26. F	Place of Death (Chec	1 Yes	24_HNO	I LI TES	Z Ser INO	
₹	hysic his ce	10 E	1 ☐ Yes 2 ☐ No	1 Inpatient	2 ER/Outpa	tient 3 🗆 DOA			dence 6 🗆 Oth		y).	
n of	ding P h. After t funera	ate:	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time injur	y wor	ryat k?]Yes 2 □ No	28d. Describe f	now injury occur	red		
Sio	Attend r deatl cctor: by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			street, factory, office	1 165 2 110			er or Rura	I Route Number,	
Division of Vital Records, P.O. Box 68	tal or safte		4 - Hollinoide determined	building, etc. (Specify)			City or Tov	vn, State)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completed birector. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner:	On the basis of exar	mination and/or in	vestigation, in my opin	ion, death occurred a	at the time, date a	and place, and du	ie to the ca	ause(s) and manner stated.	
	o the	Ĕ	only one) 3 Certifying Nurse Pr 29b. Signature and title of certifier	actioner: To the be		29c. Licens	se number		e cause(s) and m 29d. Date signe			
	⊢ s ⊢ ó		17 Wil-	m.C)	D40	120		A			
	'		30. Name and address of person who comp		th (Item 23a) (Typ	e, Print)			May			
				710 Char	her D	D 46 e, Print) COL.	-5161 12	70	7104	4		
	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 6 2011	. Hegistrar's	Signature	arkel						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 2011 Month Physician/ 6:10 John B. Conwell May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death **Examiner** Baltimore 435 Bloom Street 7. Age (In yrs. last birthday) 76 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-30-5987 Months Hours 4 /23 / T 935 NC 1 X M 2 □ F **Director** Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director N/A Baltimore MD X□ Yes 2 □ No 10f. Zip Code 21217 10e. Street and Number 10g. Citizen of What Country? Funeral 435 Bloom Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces 1

☑ Never Married 2 ☐ Married ve 1955-64 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give SpecifAmer. 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ft. Meade Elementary/Seconday (0-12) College (1-4 or 5+) Chief Engineer 12 permit. Page 1 and 2 should be filed of Department of Health and Mental Hyy Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Martha B. Gowan ပ္ John R. Conwell 19a. Informant's Name/Relationship (Type, Print) aughter JacQuetta Conwell-Brandon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12804 Walbrook Ave, Balt., MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 5/21/11 Arbutus, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA Signature of Juneral Sen 5126 Belair Rd,Balt.,MD 21206-5105 Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ C3/00 SINCEL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 Unknown as been signed by the 2 should be detached g 🗌 Unknown Part II. Other significant,conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy s certificate ha perform death? 1 Yes 2 No __ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 > Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number MRY KO, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 VAN 13040 Day 6 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bas tomore Vir Knucor Birthplace (State or Foreign Country) Social Security Number unk 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 □ F Months Days Hours July, 31 Year 1959 51 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Randallstown MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21133 8419 Randallstown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' 0. Black, White, etc. 2 1 Never Married 2 Married unk 72 hours after ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant, If item 27 is marked other than "natural", white If Yes, Give 3 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unle unk 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Northwest Hospital 5401 Old Court Road Randallstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state any injury 21. Sign ture Funeral Se State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner YParp Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that the death certificate be executed and -trans that initiated events physician ar s the burial-to resulting in death) Last Due to (or as a consequence of): Physician/Medical ending pro Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter for in the past 12 months? Day 2 🗌 No 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law equires 2 Ne 3 ☐ Probably 4 ☐ Unknown 1 Tyes director, page 2 should een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Physician; æ 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? 1. Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 \square Pending work? injury 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1. 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1005663

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

Kd

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13, 5:45 A M 2011 Richard Michael Cernak Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 4328 Conifer Ct. Glen Arm 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Days Hours 213-26-6284 10/27/1929 Mary land **Director** Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 100 Harborview Drive Unit 2007 U.S.A. 21230 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Restaurant and Elementary/Seconday (0-12) College (1-4 or 5+) 4 General Contracting Owner Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frances Dembeck Henry Cierzniak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2515 Boston St. # 908 Baltimore, Maryland 21224 Cheri Cernak / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date □ Burial 2 □ Cremation 3 □ Removal from State | cemetery, crematory or other place)
□ Donation 5 □ Cother (Specify) Entombmen □ Dulaney Valley Mem. May 18, 2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Parkinsons disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events southing in dooth), act Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director; is 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital Other: 4 Nursing Home 5 Residence 6. Other (Specify) Daughter Residen ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) M 00045749 May 7011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultime, MI) 21202 Site got st now! flame Robert Danidson MD 301 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

			State of Maryland / Depa	artment of Health and Me tificate of Death								
	Physici /Medio		1. Decedent's Name (First, Middle, Last) AUGUST B DOAK		05 0	3. Time of Death 3. 2011 OL+ 10 P M						
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Westower Ec	I	3 Omerest						
I	Funeral Director		5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 1 ✓ M 2 □ F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Date of Birth (Month, Day, Yea (O) O4 1	9. Birthplace (State or Foreign Country) Ohio						
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit									
Maryland 21215-0036	the Mar	Director	MD Somerset Westov	er 10f. Zip Code	10g. (1 Yes 2 No						
	23a or	al DI	30420 Revels Neck Road	21890		USA						
	urs after des al', or Items Transform	by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri ☐ Yes 2 No Specify:	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other treumetic event, Its Medical Extra trained by notified at ODEs.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk 16a. Deced (Give life. I	unk 16b.	Sb. Kind of Business/Industry unk							
land;	uld be filed Mental Hyg irked other tic event,	To Be C	17. Father's Name (First, Middle, Last)		ee's Name (First, Middle, Maiden Sumame) Glada Young							
Mary	d 2 sho th and h 7 is ma	i	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin		City or Town, State, Zip Code) er, MD 21890							
Baltimore,	Pages 1 an ent of Heal nt: If item 2 ry or other		20a Method of Disposition 20b. Place of Dispo			Location - City or Town, State						
Balti	permit. I Departm Importer any injui		21. Signature of Euneral Sovice Licenses Ronal a S. Wale Wirtector	Name and Address of Facility State Anatomy Board Baltimore, MD 2120		Baltimore Street						
	Physician /Medical Examiner	er	Sa. Pan I. Enter the disease, or complications that caused the death. Do not ent shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or 35 consequence of):	Approximate Interval Between Onset and Death								
68760,	ficate be executed physicien and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
P.O. Box (To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year						
rds, P.	quires that n signed b	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the u	23e. Did tobacc	2 No 3 Probably 4 Onknown							
Division of Vital Records,	The law requir ete has been si page 2 should	complete		24a. Was an autopsy performed 1 Yes 2								
Vita	Physiclan: The la r this certificete has aral director, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death (th (Check only one)							
on of	iding Phys th. : After this funeral di	ıtlon; To	1		e 5 Hesidence							
Divisi	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined 6 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	e Hospite 124 hours e Funere tetely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deatled the control of the control one of the control of the control of the control one of the control of the control of the control one of the control of the									
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number 500 62 467	29d.	Date signed (Month, Day, Year) 0 5 0 3 2 0 1 1						
			30. Name and address of person who completed cause of death (Item 23a) (Type, ALL YAHYA 3 0420 ReV	Printi ells neck rd h	Jestove/	MS 21890						
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	e, V.J								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **BRENDA** JOYCE GRIEB 12 201 a MAY 1:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🔀 52 02/25/1959 MARYLAND Director 214 78 6016 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** MD BALTIMORE RASPEBURG 1 🗌 Yes 2 🔀 No 10e. Street and Numbe ò 10g. Citizen of What Country? ,s 23a o, c must b 4515 FOREST VIEW AVENUE 21206 USA , or items Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status th and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE 12 NURSING HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HUFHAM CONN WILLIAM HELEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 FOREST VIEW AVE BALTIMORE, TODD SPALT/SON Department of Health Important: If item 2 any injury or other to once. MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/16/11 METRO CREMATORY BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Juneral Service Licensee CHESACO AVE BALTIMORE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Conci disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 XNO Other: 200 ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year) 32.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RANCE 2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death ALTINORE OSP 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 🔀 F 19-30-625 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** timore ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U-SA Longar rral", or items? 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) FILTER SERVICE Comp FFICE Z Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Boughman Teres PATENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21222 ANICI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location Burial 2 ☐ Cremation 3 ☐ Removal from State 4Ay 17, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility an 26 23a. Part 1. Enter he disease, or complications that caused shock, or heart failure. List only one cause of a ach line. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause Final Ph_sician/ DI disease or condition resulting in death) Medical Examiner Esquentially list our ditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Physician: The law requires that the death certificate be executed as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2 N 2 No 1 Tes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 📉 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural injury 5 Pending work?
1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) (Z

W.

State Registrar 10515

30. Name and address of person wherecompleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #368e BeMatthand 15Defalthent Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 10:00AM Gladys P. Gilliam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Hours $\frac{75}{}$ 86 VA Director 577-32-5699 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No Prince George's MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20706 6908 Woodstream Turn USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🖾 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7: h and Mental Hygiene. **7 is marked other than** Elementary/Seconday (0-12) College (1-4 or 5+) Subway Sandwich Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Charles Lewis, Sr. Blanche Alsop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Gilliam/Husband 6908 Woodstream Turn Lanham, MD 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 05/18/2011 Brentwood, MD 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Atherosclerotic Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any leading to immediate Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 1 Yes 2 L 9 Unknown cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 Tyes 2x No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury XNatural 5 Pending ___vatural

Accident

Suici investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Castro, MD 8118 Goodluck Rd., Lanham, MD 20706 Elena M. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5553 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [□]2011 May 12, 2:50 PM Edwin Lewis Harrison Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Windsor Mill 3416 Abbie Place 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** ודלה, Day, ב ב 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours 219-18-9342 86 **Director** 1924 Maryland 0ct Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Windsor Mill MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3416 Abbie Place 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ X Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C & P Telephone Comp Installation Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Catherine Uebel Russell Joseph Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Gaither Road; Windsor Mill, MD 21244 Donna Harrison Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lørraine Park Cemeterly 5/16/2011 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Vine al Service Lic Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 🗌 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ဂ္ 1 🗌 Yes 4 ☐ Nursing Home 5 📉 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles

State Registrar 31. Date filed (Month, Day, Year)

1 6 2011

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32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{Year}}{1}$ Humphreys Connie Lee May 12:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dundalk 2012 Dineen Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** nth, Day. Year) 1955 1 ☐ M 2 💢 F Days Hours 55 Yrs Maryland 217-68-1791 Oct. **Director** Usual Residence of Decedent show 10a, State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f **Dundalk** MD Baltimore 1 Yes 2 X No 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 2012 Dineen Drive 21222 United States permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ? any injury or other traumatic event, the Madis 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Convenience Store Retail Clerk 11 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald M. Schroyer, Sr. Betty L. Younkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Product Marvland 21222 19a. Informant's Name/Relationship (Type, Print) Brother Dundalk, Maryland Donald M. Schroyer, Jr. 2012 Dineen Drive Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, Hilltop Service Corp. 5/16/2011 Towson, Maryland ☐ Denation 5 ☐ Other (Specify) Funeral Service Licer 21. Si nature Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interest or an armount of the cause). Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 the **as** IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 █ No Month Day Year Pregnant at time of death 5 Other (specify) Yes signed by the a detached ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 € Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law has page 2 autopsy performed? After this certificate 2 C N 1 Yes 2 🛤 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Вe examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 2 PNo 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Matural work? death. 24 hours after death. e Funeral Director: A bleted filled in by the fu 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖤 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed ca

VERI

940 ENTIEN AVE

(Item 23a) (Type, Print)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alice M. Johnson 4:30A.MM May 12,2011 Medical 4a. Facility Name (if not institution, give street and number) 5003 Litchfield Avenue Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) 1 □ M 2√□ F 7irqinia 231-42-9761 **Director** June 14,1937 Usual Residence of Decedent 3a or 28a-f show be notified at 10h Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A Maryland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21215 USA "natural", or items 23. 5003 Litchfield Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify:Black Completed 3 ₩ Widowed 4 Divorced 3 2 should be filed within 72 hours a alth and Mental Hygiene.
27 is marked other than "natural r traumatic event, the Medical E) Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) eterans Administration Elementary/Seconday (0-12) College (1-4 or 5+) Cashier **H**ospital 12th arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Johnson Sallie Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 5003 Litchfield Ave Baltimore, Maryland 21215 permit. Page 1 and 2 s.
Department of Health a.
Important: If item 27 is:
any injury or other Judy J. Burden/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/19/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE RENAL FAILURE Physician/ disease or condition resulting in death) Medical CEREBRO-VASCULAR ACCIDENT

Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying DIABETES MELLITUS TYPE II to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PEMPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown EPILEPSY 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending after death.

Director: Af 1 Yes 2 No Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the base of examination and/or investigation. Medical 29a. Certifier Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce MAY 16,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RMNOLD DEPESTRE, MD 3100 LOAD BALTIMORE DR HIIV BALTIMORE MD 21244 31. Date filed (Month, Day, Year)

MAY 1 6 2011

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEWIS DUNCAN **JERNIGAN** $\mathbf{MAY}^{\mathsf{Month}}$ 15^{Day} 2011 5:17 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5312 GLENTHORNE COURT ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 1 X M 2 1 Hours 11/23/1920 N. CAROLINA Director 261-28-2197 90 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD BALTIMORE ROSEDALE 1 Yes 2 XNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5312 GLENTHORNE COURT 21237 USA death w item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces 01 Completed by 1 Never Married 2 X Married 1 Yes 2 X No be filed within 72 hours after 3altimore, Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) CONSTRUCTION WORKER 0 CONSTRUCTION marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CORNEALOUS D. **JERNIGAN** MARY Ε. DUPREE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a MARTHA A. JERNIGAN/WIFE 5312 GLENTHORNE CT. BALTIMORE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or of once. cemetery, crematory or other place) 1 Normal 2 Cremation 3 Removal from State OAKLAWN CEMETERY 05/18/11 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death Day Year 2 No 9 Unknown g Unknown by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Ullaknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st Hospital or Attending Physician: The law performed' Yes 2 No 1 Yes 2 🔲 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 410 Other: 1 🗌 Yes ည After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending М Accident Investigation the Funeral Director: mpleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 29d. Date signed (Month, Pay, Year) MD and address of person who completed cause of death (Item 23a) (Type, Print) 0 SUTTB BALTEMORE MD 101 65 01 N CHARLES

State

Registrar

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 am Vincent Bernard Johns Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Greneral ltimore N/A If Under 24 Hrs. 8. Date of Birth
Hours Min. 0 6 7 0 6 7 19 4 9 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days 216-50-3201 Maryland **Director** 61 Yrs Usual Residence of Decedent show 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Me Ical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Co. Randallstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8604 Liberty Rd. 21133 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) unemployed N/A Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George A. Johns Josephine G. Colvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Johns(brother) 1420 Ingleside Ave., Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1. Department of I Important: If its 1 Burial A Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 05/17/11 Baltimore, MD any in 21. Sign dure of Funeral Servi Joseph Adress of FBrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy nerform After this certificate funeral director, pag 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: ည 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗀 Pending Accident hin 24 hours after death.

the Funeral Director: A
mpleted filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cause(s) and manner stated. (Check 3 🗖 within 2 To the F only one) 29c. License number 20064788 29b. Signature ape 29d. Date signed (Month, Day, Year) 10 2011 Tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 821 SHARMA RALTIMORE N. EUTAW ST SUITE 301. MD 2120 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Klimovitz **Gladys** Mae 2011 6:40 A M 10 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Glen Meadows Health Care Center Glen Arm Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min. May 923 238-30-7514 88 North Carolina Director Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21093 United States 205 Belmont Forest Court Unit 401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Vas Decede... Armed Forces? □ Yes 2x2xNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed within and Mental Hygiene 7 is marked other th 11 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ambrose Payne Nellie E. Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trai 205 Belmont Forest Ct. Unit 401 Timonium, MD 21093 Linda Petrelli (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/2011 Holly Hill Mem. Gdns. Middle River, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. scha Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final hrome orn me we whomow Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No lere Son asculas death? certificate 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 No M neral Director: A I filled in by the fi Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennifer King		1- For State Registrar	tate of Marylan		artment of rtificate of		d Ment	al Hygien		2 0	Market Street	15559
Physician/ Medical Examiner		T ! C 77 !									3. Time of Death 2121 hrs	
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Death Baltimore									4c. County of		
Funeral Director		5. Social Security Number 220–98–5723	6. Sex 7.	Age (In yrs. i	last birthday) Yrs	If Under 1 Yea Months Days		Min		(MM/DD/YYYY) /1981	Foreign	
w any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					- 1	10d. Inside City Limits
Maryland 28a-f show	Director	MD Ba1 10e. Street and Number	timore		Dunda1k					1 Yes 2 No		
with the Maryland ms 23a or 28a-f sho be notified at once.		7309 School A	venue	ent Ever in U	S. 113 Wa	2122 as Decedent of His		n? (Specify Ye	or No-	United		tes an Indian, Black,
or ite	by Funeral		Armed Force 1 Yes Vorced If Yes, Give Year or Date:	es? 2 X No	If Y	es, specify Cuban	, Mexican, I			White,	etc.	nite
5-0036 lled within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 11 Years	cify only highest grade		during m	t's Usual Occupat ost of working life.	. DO NOT u			16b. Kind of Bus		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle			Pni	obotomis	18.Mother's			Health aiden Surname)	Car	re
Me Me	To Be										Zip Code)	
e, MD 1 and 2 sho Health and item 27 is		Mr. David P. I		20b.	Place of Dispos	9 School ition (Name of cer		ue Dun		Maryl 20c. Location - 0		21222 own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other S	pecify:	otato		Cemetery		5/9/201			_	, Maryland
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Ir 7922 Wise Ave. Dundalk, Maryland 21 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
Physician Examiner	- 1	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Methado</u>	ne and	cocain				ory arres	st, shock, or hear	1	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co									
isi ed of	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								_	
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Vital Rec hysician: The I this certificate I	To Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No		atient 2	ER/Outpatient		Other 🗔	Nursing Home	5 🗌 R	esidence 6	Other:	
ion of tending Pheath.		27. Manner of Death 1 Natural 5 Pend		ıy,Year)	28b. Time of Ir		y at Work? 'es 2 🕱 N	No -		w injury occurred	d	
Natural 5 Pending Investigation 1 Pending Investigation 2 Pending Investigation 2 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) Motel room 1 Natural 2 Accident 3 Suicide 6 X Could not be determined (Specify) Motel room 28e. Place of Injury - At home, farm, street, factory, office building, et (Specify) Motel room 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the property of the pass of examination and/or investigation, in my opinion, death occurred and manner stated.								Unknown				
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated. 29b. Signature and title of certifier 29d. Date of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.												
	Ĭ	29b. Signature and title of certifie		1		29c, License O.C.M				29d. Date signed May 4, 2011		ı, Day, Year)
P		30. Name and address of person Zabiullah Ali, M.D.	who completed cause of Assistant Medical	•	,	altimore Stree	et, Baltim	nore, MD 21	223			
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	ire							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Jaysen Kevin Kim May 9, 2011 Year 7:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Germantown Montgomery 13201 Croppers Mill Dr. Apt L. 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Nov 1, 1970 Days CA Director 219-11-6207 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director s 23a or zo... must be notified a' MD Germantown Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13201 Croppers Mill Dr. Apt L. 20874 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates. preav other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Liquor Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injuy or other traumatic eve once. 2 Sally Altman Jung Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13201 Croppers Mill Dr. Apt L. Germantown, MD 20874 Stacey Kim Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 11, 201 Glen Burnie, MD Atlantic Crematory, LLC 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 ture of Funeral Service Licensee MO053 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Early Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of): law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 X No 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 9 2011 1 ☐ Yes 2 No M Accident Investigation Unh Suicide 6 Could not be 28e. Pace of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) HO mas Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 22 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ature and title of certifier 29d. Date signed (Month, Day, Year) Door MOOME 524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER mo OME Selver State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ MAY 12 11:56A M EDITH KLAPPER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TUDOR HEIGHTS BALTIMORE BALTIMORE If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2🛣 F Months Days Hours Min 07/07/1921 89 NY Director 062-16-8993 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tes 2 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7218 PARK HEIGHTS AVENUE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 HOMEMAKER OWN HOME should be filed with and Mental Hygier is marked other the Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ EDELSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6200 VERDENE AVENUE BALTIMORE, MD 21209 DR. MITCHELL KLAPPER / 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ANSTITE TELEPINISMENT OF other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/13/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Schera Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MO Medical **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 1000 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) ASST, LIV/N ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

68760

Box (

P.O.

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

2700

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ouarry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 11^{Day} May Month Physician/ 2011ª 11:41 ам Marv E. Kerr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Silver Spring Renaissance Gardens If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Funeral Age (In vrs. last birthday) Country) Ohio Days ^{Year} 9<u>30</u> 1 D M 2 X F Min. Mar 13. Yrs. Director 299-26-5850 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 No Prince Georges MD Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 3160 Gracefield Road 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 X Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude Pickett Edward Thatcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10872 Sandringham Road; Cockeysville, MD 21030 Douglas S. Kerr son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Commation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Dulaney Valley Mem Gardens 5/13/</u>2011 Timonium, MD 21. Signature of Fun 22. Name and Address of Facility 1050 York Road MD 21204 Towson, Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one capts that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death UNKNOWN Immediate Cause (Final Physician/ Concestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner unknown Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 X Unknown Diabetes Mellitus II Completed 24b. Were autopsy findings available prior to completion of cause of death? Arteriosclerotic Cerebral Vascular Disease 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tyes 2 😾 No 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 5866 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Rd.; Silver Spring, MD 20904 Eileen Gemmell 6

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY MARIE BARBARA LIVINGSTON 2011 4:15 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8 Date of Birth **Funeral** 6. Sex Age (In yrs. last birthday) 1 □ M 2 🗓 F Days Months 0 1 1 6 1 9 2 6 220 12 8205 MARYLAND Director 85 Yrs. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD n/a BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 845 N. COLLINGTON AVENUE 21205 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. RECEPTIONIST CHURCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK MICHAL BARBARA NOVAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL LIVINGSTON/SON 3037 E. NORTHERN PARKWAY BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HOLY REDEEMER CEM 5/16/11 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Furniral Service Lice se 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) ing physician and e as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical Box 68760 attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year 2 No eral Director: After this certificate has been signed by the ifilled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ear 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License numbe M031 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.2300 Dulaney Valley Road Ernestine Wright, Timonium MD21093 31. Date filed (Month, Day, Year) 32. Regis rar's Signature State Registrar

:41

10d. Inside City Limits

1 Yes 2 No

9. Birthplace (State or Foreign

20012

Dav

2 XN0

2011

29d. Date signed (Month, Day, Year)

MAY

Approximate Interval Between Onset and Death

EVANCICH MD 9901 MEDICAL CENTER DRIVE ROCKVILLE MD NICOLE 31. Date filed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29a. Certifier

(Check

only one

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 800 Rita A 2011 Medical 4a. Facility Name (If not Institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLin Square Hospital Rosedale Baltimore 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Date or Day, Ye **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Country) **Director** 218-40-231 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 ☐ No Hingham timore 10e. Street and Number 10f. Zib Code 10g. Citizen of What Country? Funeral 36 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 19 rocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Houser Kovalevski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21160 dughter Main Anne Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date UUK 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Allentauni 21. Signature Jun Service Li 22. Name and Address of JESSUP, PA 18434 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shop Immediate Cause (Final Onset and Death Physician arrest disease or condition a Cardio ulmonary Medical resulting in death) Due to (or as a onsequence of) Examiner Left STroke Massive th 2 brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 9 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ congestive hearT Failure 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATrial Fibrillation page 2 s autopsy performed Gastrointestinal bleedin certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b, Time of 28c. Injury at work? 1 Natural 5 Pending Accident
Suicide 1 Tes 2 No after death Director: / Investigation the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALHau

DRMchammed

31. Date filed (Morth, Day, Year)

RES 0000

9000 FRANKLIN Square DR Baltomd 21237

5-11-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year 130 PM 2011 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours 2-26-1947 216-48-4004 64 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD N/A Baltimore City 1 X Yes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 3908 Erdman Avenue 21213 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ₺ Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 ! n and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) N/A Attendant Laundromat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. 2 Thomas Waesche Cora Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Jones - Son 7536 School Avenue Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Encombment 5-16-2011 Oak Lawn Cem. Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of), Exami Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performe 2 🗆 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Director: 3 🗆 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after
To the Funeral Direcompleted filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur

State Registrar 30. Name and address of person who

ULINON : CA HO
31. Date filed (Month, Day, Year)

X DHMH 17 Rev 7/2009

death (Item 23a) (Type, Print)

completed cause/t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chandler Carolyn McNeil1 2011 ĩŏ 7:30 A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. 2828 Wells Avenue Edgemere 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Nov. 21, Year 1945 214-44-0732 Maryland Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Edgemere 1 🗌 Yes 2 🔀 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2828 Wells Avenue United States 21219 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 🗌 Yes 2 😾 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 XWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, Important, If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Hair Stylist Cosmetologist Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harriet Acheson Dickerson William Theodore Brown, Sr. 19a. Informant's Name/Relationship (Type, Print) Daug ter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley A. McNeill-Giangrasso Edgemere, Maryland 2828 Wells Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Timonium, MD Dulaney Valley Mem. Gdns.5/13/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the o shock, or heart fa sease, o) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lure. Lier only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi Physician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2/X No has page 2 1 ☐ Yes 2 X No this certificate 25. Was case referred to medical director. Be 26. Place of Death (Check only nel examiner? Other: 1 Tyes ဂ္ 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death ė 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. iniury 1 Natural 5 🗌 Pending work?
1 Yes 2 No Certificat Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier satifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

6

State Registrar

29b. Signature and title of certifi

31. Date fled (Month, Day, Year,

6

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ne

sau

29c. License number

29d. Date signed (Month, Qay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 15 Physician/ PM 201 HM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 6E ONTGOMEKO E OCKVILL Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Z. Age (In yrs. last birthday) If Under **Funeral** (Month, Day, Year) 4/23/1922 Months Hours Min Country) Ohio 1 🗆 M 2 🗓 283-18-7066 89 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mine to account of the Medical Examinar mines. 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2🏝 No MD Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code USA Funeral 9701 Veirs Drive 20850 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. ð 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Arthur Wensinger Vergie Samsell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Crispell/Son-in-law 22 Cameron Road North East, Md. 21901 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 Removal om State Chesapeake Crem. 5/13/2011 Beltsville, Md. 4 Donation 5 Other (Specify) PHIMIP ADDES RINALDI FUNERAL SERVICE, P.A. 21. Signat unerad Service Columbia Blvd.Silver Spring,Md20910 ng, such as cardiac or piratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause ach line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner N. Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequ ence of sician and bunal-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown ed by the a detached f 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed of 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s this certificate has performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Hospital: Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature . Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 7/2009

9701 Veirs Drive Rockville, Md 20850

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

MD

32. Register's Sig

Charles Karesh

31. Date filed (Month, Day, Yea NAY 1 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M_{ay}^{Month} 2, 201110:30 PM Patricia Neal Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery 01ney If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 4, 1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours Iowa 479-52-4032 **Director** 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

any injury or other terms. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20906 USA 2601 Bel Pre Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc þ 1 Never Married 2 Married ☐ Yes 1 ☐ Yes 2 X No Specify: white Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) department store 12 0 cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ona Boster John Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Neal/son Tecovas Springs Ct Killeen, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Funeral Service Licensee Rona d S W State Anatomy Board 655 W. Baltimore Street Baltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Einal Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 9 Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Dav Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1240 ၉ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 74 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Onley, MD 20832 18111 Prince Phillip Dr. Ste 101 Ata Motamedi 31. Date filed (Month, Day, Year) State 1 6 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Joseph	Nola	1- For State	ate of Maryla	nd / Depa	artment of	f Health an	d Mental I		201	1 1557		
Physic	ian/	Registrar						2. Date of Dea		3. Time of Death		
Medical Exam				Month May 3, 20	Day Year 11	1508 hrs						
		James J. No1an 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location					Location of Dea	ith	4c. County of Dear	th		
		310 Stoney Run Circl				North East			Cecil			
Funeral		5. Social Security Number		7. Age (In yrs, I	last birthday)	If Under 1 Year Months Day			th(MM/DD/YYYY) 9. Bi Fore			
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21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	19a. Informant's Name/Relations			19b. Mailing	Address (Stree		Coakley or or Rural Route Number, City or Town, State, Zip Code)				
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of Viding Physic	2	1 ✓ Yes 2 No		patient 2	ER/Outpatient	0			Residence 6 🗸 Othe	r: Scene		
ding Ph	Ë	27. Manner of Death 1 ✓ Natural 5 □ Page	28a. Date o (Month,	of Injury Day,Year)	28b. Time of Ir		y at Work?	28d. Describe h	now injury occurred			
isior Attend r death rector: by the	cation:	- Pend	stigation	=			es 2 No					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral director	ertific	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)								ural Route Number, City		
ospita hour unera ly fill	0	29a. Certifier	(Openiny)			and at the class of the		1.1	(1)			
To the How within 24 h	Medical		miner:On the basis of	examination a					e(s) and manner as state and place, and due to th			
To with To	Me	29b. Signature and title of certifie	and manner sta	ated.		29c. License	e number		29d. Date signed (Mo	onth, Day, Year)		
		1/2/11	1 1 1	7/		O.C.N	M.E.		May 4, 2011			
	ŀ	30. Name and address of person	who completed cause	of death (Item	23a)							
		·	Assistant Medica	•		altimore Stree	et, Baltimore	e, MD 21223				
S	ate	31. Date filed (Math. Day, Year)	2011 320 Rec	istrar's Signati	ban	Les .						
Regis	rar	117(1 = 0	Mosto	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 01dham 9:30 a^M G. 13 Florence May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** 1 M 2 X F Months Hours Septh, 21 Year 1916 94 065-09-8207 Maryland Director Usual Residence of Decedent shov 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🗚 No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21234 8800 Walther Blvd., Apt. 1214 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Investments Research Director 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gillespie Alice 01dham Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8800 Walther Blvd., Apt. 1214, Parkville, MD 21234 Virginia L. Mann-friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Towson, MD Hilltop Serv Corp 5/16/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Sovice Licensee William G. Dau 1050 York Rd., towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADVANCED DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available HYPERTENSION 24a. Was an performed 1 \sum Yes Yes 2 No 25. Was ca referred to medical examiner?

1 Yes 2 \sum No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending MAY 8 2011 UNNITWESSED FALL Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined MORNINGSIDE Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) and address of person who completed

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 3:30 Å M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Howard Stanley PAUL Physician/ Ma^{Wont}12, 201/1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Anne Arundel **Examiner** Glen Burnie Glen Burnie Health & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Ap(Wonth, 21), Yea 1936 Hours 75 Director 119-26-8774 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No 0denton Maryland Anne Arundel 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral United States 21113 8601 Roaming Ridge Way #302 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces?
No Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates. Specify: white '60-'62 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry مtin with. خوا Hygiene. خود than "ح (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked of ၉ Lillian Cohen Moses Paul traumatic permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Paul, Daughter West 30th St., #4F, New York, NY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery | 05/18/2011 Cheltenham, MD 21. Signature of Funeral Service Licensee Forechainsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part to ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary arter 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Prnysician. The Within 24 hours after death.

To the Funeral Director: After this certificate has To the Funeral Director: After this certificate bags 2: autopsy
performed?

Yes 2 10 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: <u>1</u>0 Other: 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of contin 29c. License number 12/2011 NLD

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Hickory Sw

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 14 per th g915 5-16-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical lervin Eugene 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Allegan Western MI Health and Prthplace (State or Foreign Country) If Under If Under 24 Hrs. Date o. (Month, D . Age (In yrs. last birthday) 8. Date of Birth Security Number **Funeral** 1 X M 2 🗆 F Months Days Hours Min. Day, 9 **Director** MD 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location within 72 hours after death with the Maryland Director ıral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 429 Independent 8031B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc.

Black "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) 19 laintenance Itame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rogier beth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Green Piedmont lima Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date UNK 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 M Donation 5 ☐ Other (Specify) Allentown, PA 21. Signature of Furjeral Service Lice 22. Name and Addres of acility 1232 Midvaller PA18434 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiamy o pathy Severe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ē Due to (or as a consetuence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 25 No ဂ္ 1 Nonpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, D 00 68 455 5,12,11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 willow brook road, Cumberland, MD 21502 Enkeshuf 31. Date filed (Month, Day 5 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** huth hoch 05 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔽 212-05-3734 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Director Dundalk MD pundalk 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A a1 aaa moad 2 Flagship Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 €
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Linite ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4 or 5+) Monarch Dry Cleaners 12 Years Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John McDonough Rena Betz မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8224 Carrbridge Circle Towson, Maryland 21204 Gerard Wittstadt (Attorney) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 1 XBurial 2 Cremation 3 Removal from State Most Holy Redeemer Cem. 5/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications disease or condition resulting in death) VEDTI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, Due to (or as a consequence of): attending physician a for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 Mo Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Atrial fibrillation 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronan arteru 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 des 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 2 ER/Outpatient 3 □ DOA 5 Residence 6 Other (Specify) 1 🗌 Inpatient မ within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0028684 May 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Desim an 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 16 2011 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SZULCZEWSKI Physician/ ERARD 1:59 PM 2011 Way Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balti was Age (In yr ... 81 If Unde If Under 24 9. Birthplace (State or Foreign last birthday) 8. Date of Birth **Funeral** Month, Day, AUG9 . 1 214-24-6776 1 X M 2 □ F Months Days Hours MARYLAND **Director** Usual Residence of Decedent 28a-f show 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director BALTIMORE CITY 1 XYes 2 □ No MD. ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21224 3126 ELLIOTT STREET U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc "natural", or 1 Never Married 2 Married ò within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working than UNIVERSITY should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTER OF MARYLAND 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BERTHA PONIATOWSKI JOHN SZULCZEWSKI 19a. Informant's Name/Relationship (Type, PrinDAUGHTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a CHERYLE SZULCZEWSKI 3126 ELLIOTT STREET BALTIMORE, MD. 21224 other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot MAY Date 14. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2011 HRT OF JESUS BALTIMORE,MARYLAND SACRED 22. Name and Address of FaciliKACZOROWSKI FUNERAL HOME, PA 21. Signature of Funeral Service Licensee 1201 DUNDALK AVENUE BALTIMORE, MD.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final hom acquired tactor X Del Ph sician/ 6 weeks disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a conse resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 1 🗆 Yes 2 🗆 No 1 Yes 2 No 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Certificate: 27. Manner of Death 28a Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) work? Natural 5 Pending 2 🗌 No death Μ within 24 hours after death To the Funeral Director, / completed filled in by the f Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print ST. Paul ST. 301 NAZARIAN 31. Date filed (Month, Day, Year, State 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1- State Amend Items 23aPt1, Pt11, 23e, 25, 27, per me, 9915, 05/16/2011dnb Reg. N 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:03 P.M April 29, 2011 Michael Paul Saraullo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5687 Harpers Farm Road Unit C Columbia Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 X M 2 □ F 216-72-3828 Yrs. 54 June 29, 1956 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment must be redified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🛛 No Director MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 USA 5687 Harpers Farm Road Unit C by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 □Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Manager Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Paul Saraullo Nancy Lee Roelecke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debra Saraullo 2 Harding Street; Timonium, MD 21093 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem.Gar. 5/3/2011 | 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or, liac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Hyperiens ive Atherosclerotic

ardiovascu Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 V Willen **Physician** Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): ルンネイエッギンプ Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Chronic Lung Disease** 1 ☐ Yes 2 ☐ No 3 X Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 □ No 2 🗆 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Deal 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide ould not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifia (Ch k only o e) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Mpnth, Day, Year) 29b. \$ignature and title of certifie 29c. License number

Registrar

State

me and address of person with

16

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per f.h.g915 5-16-11 sm State of Maryland / Department of Health and Mental Hygiene 2 1 1 State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Margaret Elizabeth Soellers Month May 1 I pay 201 I ear Physician/ 3:00 PM Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore City 3009 Elliott Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Month, Day, Year) eb. 29,1924 Months Days Hours Min 1 🗆 M 2 🔀 F Maryland 216-14-7949 87 Feb. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore City N/A 1X Yes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21224 3009 Elliott Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) American Can Co. Computer Operator 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ဥ Margaret E. Freund David F. Murphy Niece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollie L. Rakowski-Griffin 3009 Elliott Street Baltimore, Maryland 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/16/3891 Middle River, MD Holly Hill Mem. Gdns. 4 ☐ Donation 5X Other (SpecifyEntombment 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death COLUREC Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for es e nonsequente off trany, leading to himediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical \mathcal{MAL} \mathcal{CARCT} \mathcal{S} Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav Pregnant at time of death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 1 Yes 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate; Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 □ Sulcide 4 □ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) 11/2011 who completed cause of death (Item 23a) (Type, Print) 6 State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midral Ever in a country in other and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	-	For State Registrar	Ce	rtificate of L	Death	Reg	J. No.					
		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death				
icia dica		Park Arthur Snyder Sr					O11	4:30 AM M				
nine		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Deatl	n	4c. County of Dea					
		15504 Rose Court		Emmittsl			Frederic	Κ.				
al or		5. Social Security Number 513-12-5735 6. Sex 7. 1 ₹ M 2 ☐ F	Age (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month Day)	(e <i>ar</i>) 9. Bir 2923 K	thplace (State or Foreign ountry) ansas				
	ļ	Usual Residence of Decedent	10d. Inside City Limits									
	١	10a. State 10b. County	10c. City, Town or L					1 ☐ Yes 2√ No				
	Sct	MD Frederick	Emmo	ittsburg								
	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	ountry?				
		15504 Rose Court			1727		USA					
	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl	to Rican, etc.)	14. Race - Ame Black, Whit					
	Ś	1 ☐ Never Married 2 ☐ Married if Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Date	s: 143–45	1 □Yes 2 No	Specify:		Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 0 16b. Kind of Business/I (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname)												
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		17. Father's Name (First, Middle, Last)				,						
	၉	Joseph Edward Snyder	405 145			Ellen Ki		Zin Coda)				
		19a. Informant's Name/Relationship (Type. Print) Ralph Snyder/son		ling Address <i>(Street &</i>				_				
1	- 1	20a. Method of Disposition	20h Place of Disp	osition (Name of	T T		Oc. Location - City or					
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	cemetery cre	ematory or other place	e)							
once.		21. Signature of Funeral Service Licensee Ronal d S. Name Di	rector S	22. Name and Addres tate Anato altimore,	omy Board		Baltimore	Street				
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al		disease or condition resulting in death) Due to (or	as a consequence of):	spua	Tory y	aceare		3 days				
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	Examiner	cause. Enter Underlying Cause (Disease or injury										
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	ပ္	200 Contifier 1 Contituing Physician, To the b	mo doto and plac	and due to the ag	uuso(s) and mannor	ae etated						
	Medical Certification: To	29a. Certifier (Check only one) A Certifying Physician: To the base and manne	is of examination and/or	investigation, in my o	ppinion, death occ	urred at the time, da	ite and place, and di	ue to the cause(s)				
	d. Date signed (Mor	nth, Day, Year)										
		1 Local Hos	per M) DOO	22819		MAY 5,	2011				
		30. Name and address of person who completed caused BRAD J. COOPER, M.D.	of death (Item 23a) (Type 52 WA7	ER ST.	THURM	ONT, MI	0. 217	98				
Stat	e	31. Date filed (Month, Day, Year) 32 Reg	istrar's Signature			,	/					
istra		MAY 1 6 2011 /2	va B. 10	arked								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4a. Facility Name (I'not institution, give street and number) Ma 2กแ Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number No was all If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. 10/08/1929 Yrs **Director** 219-20-9932 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE OWINGS MILLS MD 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 124 STRONGWOOD ROAD 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar 3 X Widowed 4 □ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) EXECUTIVE SECRETARY CITY OF BALTIMORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ၉ EISENBERG BARNEY CELIA TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 4283 SANTA LUCIA ARC, LAS CRUCES, NM permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr ZAN STEINBERG/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State MOSES MONTEFIORE 05/13/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licen SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by brown cardin Records, cate has been signage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical **Division of Vital** the funeral director, 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, mo ted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 9:15 LORETTA THOMAS 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE HOSPITAL BEL AIR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F (Month, Day, Year) 2-09-1959 **Director** NY 088-50-2281 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No ABERDEEN MD HARFORD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral U.S.A. 202 PLAZA COURT APT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ğ 1 Never Married 2 Married 1 Y Yes 2 If Yes, Give 1 Yes 2x No Specify: Specify: BLACK Year or Dates 81-87 Completed 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. MENTAL HEALTH 12 COMMUNITY COACH permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ TURKVAN ADELLE NATHANIEL THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 SHORE FRONT PKWY 7A ROCKAWAY BEN, NY 11693 MARSHEILA TILLMAN/COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CALVERTON NAT'L Cem. 05-18-2011 CALVERTON, NY Signature of Funeral Service Lice Name and Address of Facility
LLIAM BROWN COMM.
1 S. PHILADELPHIA FUNERAL HOME-HARFORD P.A. BLVD. ABERDEEN, MD 21001 ▶ Part 1. Enter the disease or complications that caused shock, or heart failure List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pe disease or condition resulting in death) Medical Due to (or as a c. s quence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury detached for use as the burial-transit the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No 1 Yes 2 L 9 Unknown the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by idne 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy director, page 2 performed' or Attending Physician: The Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gartifying Nurse Practioner: To the best of my knowledge, di d at the time, date and place, and due to the c 29b. Signature and title of certifier 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Date filed (Montal, Day, Year) 32. Registrar's Signature State 16 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month 3 Time of Death Physician/ 0605 M Granville G. Taylor 2011 lau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Rehabilitationa Nursing Ctr spu 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Months Days Hours Min oct 5 Day, 1924 Marvland 224-20-6803 86 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director r 28a-f st notified a 1 Yes 2X No MD Salisbury Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ural", or items 23a o Examiner must be Funeral 21804 USA 200 Civic Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 XYes 2 No "natural", or þ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: white Completed 3 Widowed 4 Divorced 1943 er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) fisherman seafood is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lucy Lenore Elliott Granville George Taylor Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13047 Selby Road Bishopville, MD Charlene Robertson/daughter : If item 2 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) re o Funeral S rvice Licen State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ck, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Yes 1 | Yes 2 L g | Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ares 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 4 completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 Matural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ro

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illiam H.

MAY 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2011^{eai} Mav 9:55 A M Frederick Joseph Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, 8. Date of Birth Sex 1 X M 2 □ F **Funeral** Days Hours ^{Yea}1925 June 11, Kentucky 85 Director 405-28-6260 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 X No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō an "natural", or items 23a or Medical Examiner must be Funeral U.S.A. 634 Murdock Road 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Arreed Forces? 1 Never Married 2 Married þ 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry should be filed within 72 nand Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Electrical the Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thompson Dixie Lee Cooper Frederick age 1 and 2 sho Jepartment of Health and Important: If item 27 is me any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21212 634 Murdock Road Wife Dorotha K. Thompson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State Maryland Druid Ridge Cemetery 5-16-2011 Pikesville Donation 5 Other (Specify) 10me, 21204 Ruck Towson Funeral Inc. 22. Name and Address of Facility Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) INOM Medical (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 WNo 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 N Other (Specify) NO SOLG 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 2011 and address of person who completed cause of death (Item 23a) (Type, Print) POWSON MO W Charles CHARIKS 670i

State

Registrar

31. Date filed (Month

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/alorie Lynn Ab	elm	an (State of Maryland				and Men	ital Hygiene		2011	15583
Physici	on/	Registrar 1. Decedent's Name (First, Mic	ddle Last)	Ce	ruricat	e of Death	_	2. Date of De	Reg. No		3. Time of Death
Medical Exam		(, , , , , , , , , , , , , , , , , , ,	Valori	e L	nn	Abelman		Month May 7, 2	Day	Year	1839 hrs
		4a. Facility Name (if not institu	ition, give street and number		,		n, or Location		4	c. County of Deat Harford	h
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. I	ast birthd		Year If Und		Birth (MM	/DD/YYYY) 9. Bi	
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/ any		10a. State 10b. Count	ty	10c. City	Town or	Location					10d. Inside City Limits
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after d ul", or	by Fu	3 Widowed 4 C	1 Yes	2 X No		1 Yes 2 X	No specify:			Specify: W	hite
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examines	ed b	15. Decedent's Education (Sp				cedent's Usual Occ			16b.	Kind of Business	/industry
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21215-0036 ould be filed within 7 is Mental Hygiene. I marked other than ic event, the Medica	Be (Thomas B. Bas	scom					Kathleen		-	
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Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other trans			on 3 Removal from s	State	crematory	or other place)					
Itim it. Pa rrimen ortant	. 1	4 Donation 5 Other 21. Signature of Funeral Service		K.	а. ге	rris & Co.,		May 9, 2011			·
Balti permit. Departm Importa		Kut H	:16	1				' Hicks Ho on St., Elk	me i	tor Fune . MD 21	rals, P.A. 921
Physician		23a. A rt I. Enter the disease, failure. List only one caus		ed the death	. Do not e						Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Finel diseas	se a Cocaine	Intox	icati	ion					Death
,		or condition resulting in death)	Due to (or as a con	isequence o	f):						
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Box 68760, e death certificate be extending physiciar certificate to extending physiciar certificate as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcome the 1 Live birth	ome of preg		75	3 Ectopic	- progposm/	23	d. Date of deliver	y Day Year
x 68 h certi tendin use as	iciai	past 12 months?	4 Pregnant	at time of de	ath 5	Fetal death Other (Specify)	3Ectopic	pregnancy		WOTH	Day 1eai
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exhibit 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	ē	Part II. Other significant cond	itions contributing to dea	ath but not re	esulting in	i the underlying cau	ise given in Pa		_		the cause of death? bably 4 Unknown
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Vita	To Be	examiner?	Hospital: 1 Inpat	tient 2	ER/Outpa	atient 3 DOA		-	Reside	ence 6 🗸 Othe	r: Scene
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Division To the Hospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	Medical		taminer:On the basis of ex	amination a							
E.≥ E. 8	₹ ¥	29b. Signature and title of certif		4.		29c. Lie	ense number		29d.	Date signed (Mo	onth, Day, Year)
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		30. Name and address of person	•	,	,	0 \A/ Baltimas	Stroot D	altimore MD 242	23		
	ate	Margarita Korell MD. 31. Date filed (Month, Day, Year		- d- 0'- 4			oueel, Ba	anumore, MD 212	-		
Regist		MAY 1 6 2011	Beneva &	1. 400	and a						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 25 A Boone Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Bels reen Birthplace State or Foreign
 Country 8. Date of Birth (Month, Day, Year) ar If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Min. 1 X M 2 - F Months Hours 578-80-68 52 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Director 1 Tes 2 No Maryland F 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20747 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) of Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ nknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 5204 Geneva injury or other 20a. Method of Disposition 20b. Place of Disposition (Nume of 20c. Location - City or Town, State Date cemetery, crematory or other place) Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funday Service Light 22. Name and Address of Facility any MI 20608 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause of each line. Part 1. Enter the dis shock, or heart fail Approximate Interval Retween Immediate Cause (Final Physician/ patocellin disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: fyes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 X No Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural injury work? 5 \square Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of centifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KBG 85E AMEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY O Registrar

11-03420
Alvin L. Brower

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dharit		State of Maryland / Depa 1-For State Cel Registrar	rtificate of			R	eg. No.	1 1000		
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		Prince George's Hospital Center Cheverly Prince George								
Funeral		5. Social Securify Number 6. Sex 7. Age (In yrs. I	ast birthday)			8. Date of Bir		Birthplace (State or Foreign		
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Aaryland 28a-f show 1 at once,	ctor	10e. Street and Number	1001 11	10f. Zip Code			0g. Citizen of What			
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d be fi ental l arked vent,	Be	Alvin L Brower Jr.			Brona	Brady				
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d 2		Jaunita D.M. Brower/wife 20a. Method of Disposition 20b. 1	Place of Disposi	Brooks I	Dr. #2 ery,	01 Car	20c. Location - C	thts Md ity or Town, State		
permit. Pages 1 an Department of Hea Important: If iten injury or other tr		1 2 Denai 2 Oremation 5 Nemoval non state	crematory or oth	ner place)						
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OB Solution of the past 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? If Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Dther (Specify) 9 Unknown 23d. Date of delivery Month Day										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 4 1. Decedent's Name (First, Middle, Last) Day 25 2-0-11 Luz Brown **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Arcola Health and Rehabilitation 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, FEB • 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 □XF ĩ′925 Puerto Rico 86 Director 125-24-7616 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at 1 √ Yes 2 □ No Director Prince George's Upper Marlboro Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 USA 10711 Trafton Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 TNo Specify: Puerto Rican Specify: Puerto Rican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 ☐ No ģ 72 hours 3 ♥Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any injury or other trainment Nieve Rodriguez Vicente Rodriguez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type. Print) 10711 Trafton Drive Upper Marlboro, Maryland 20774 Kenneth Brown/Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29/11 Calverton, New York Calverton Cemetary 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 21. Signature of Juneral Service Licens 7474 Landover Road Hyattsville, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? o Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 ♣ No 2 **X**No 1 ☐ Yes e Hospital or Attending Physician: 1 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Ahmed <u>Heshmat</u> 10301 Georgia Ave. Silver Spring, MD 20902 APR 2 9 2011 32. Registr State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 1^{Day} 2011^{Year} 7:05AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LAUREL LAUREL REGIONAL HOSPITAL If Under 24 Hrs. Hours Min. 6. Sex 1 AM 2 □ F If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days MARCH^{Day} NORTH CAROLINA 80 1931 238-40-7490 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 13504 VANDIVER COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, et-1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOESIEPHENE DANCY JOHN BATTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VISTA ALEGRE COURT BOWIE, MARYLAND 20721 <u>LEESTA BRITT/NIECE</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 4/16/11 CLINTON, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. of Funeral Service Licenses 22. Name and Address of Facility Signature <u>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND</u> 20785 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Approximate shock or heart aid Immediate Cause (Final heart ailure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached g Unknown g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by abete 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b page 2 sl autopsy perform After this certificate Yes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

6

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

UNW

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ 20 CHESTER BRITTINGHAM W. Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** COMICO Sex 1 XM 2 □ F If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months JULY 31 1942 MARYLAND **Director** 68 216-40-4118 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No PITTSVILLE MARYLAND WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21850 6180 FRIENDSHIP ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 X Married WHITE 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HAZEL T. PALMER BRITTINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6180 FRIENDSHIP RD., PITTSVILLE, MD 21850 DEBBIE BRITTINGHAM/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or DENNIS CEMETERY 5/3/11 WILLARDS, MARYLAND Donation 5 🗌 Other (Specify) 21. Signaturu 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician MRLANOWA METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes Æ Ro 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖈 💭 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 005 8 400 2011 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 327 Registrar's Signature

SALISBU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marione Mar 55 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Anne medical Center Burnic Arunde Washington Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) N.C. Min. (Month, Day, Yea 458:58:6700 1 □ M 2 🗹 Hours Director Yrs Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' 0 Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Completed by aryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural", Specify: WhITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than filed within 7 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL 10 Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DILIE ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 DUNYAPRD · PASADENH, M.D.Z1122 STEPHANIE KAFFORD/ANDDA Baltimore, ethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARUNDE CREMATORY 5-13-11 ODENTON MD. Signature of Funeral Service 22. Name and Address of Facility XALERTY FUNEAR HOME 2601 MOUNTAIN RS PREADENA, MD. 21127 00942 Part 1. Enter the disease, or cor shock, or heart failure. List only medications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Cardionno Sequentially list conditions, if any tracing to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Gastro Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Physician D56950 MY 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinte 16 Gen Branie MD 21061 Park Orive Aggielm 1411 Madison Mnaemeka 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** oris Mari 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSP Anne's veen veen Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗗 F Months Days Hours 168-34-2124 Usual Residence of Decedent Director Marylano 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantuar must be notified at 1 EYes 2 No Director cha 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 12 No Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County Board of Ed. Guara permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) huels James 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veteran's Cemetery May 2, 2011 Hu

22. Name and Address of Facility
Henry Funeral Home, RA 4 ☐ Donation 5 ☐ Other (Specify) HUYlock, 21. Signature of Funeral Service Licensee CI 510 Washington St. Cambridge MD.21613 Approximate Interval Between Onset and Death or complications that caused the d-ath. Do not enter the mode of dying, such is cardiac or respiratory arrest, ist only one cause on each line. . Pa 11 Inter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** wo /Medical Examiner HRLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and burial-Box 68760. physician Physician/Medical the attending pl for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Month Year 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Sother} \) (Specify) \(\text{HcSp:ce} \) 2 **X** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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DHMH 17 Rev 1/2001

State Registrar 11-03212 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lindsey Crispino 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 27, 2011 0830 hrs **Medical Examiner** LINDSEY NICHOLE CRISPINO 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Queen Anne's Centreville 1040 Ruthburg Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director CMARYLAND JAN. 6, 1983 28 2**X** F 220-17-9342 1 M Yrs Usual Residence of Decedent 10d Inside City Limits III y 10a. State 10c. City, Town or Location 1 Yes 2 X No rmi. Pages I and 2 should be filed within 72 hours after death with the Maryland repartment of Health and Mental Hygiene.

sportant: If item 27 is marked other than "natural", or items 23a or 28a-f shou jury or other traumatic evect, the Medical Examiner must be notified at once. CAROLINE DENTON MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8630 HICKORY PLACE UNITED STATES 21629 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 1 Yes WHITE 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Yeer Specify \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NICK VINCENT CRISPINO, SR. KIM SPRINKEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIM CRISPINO/ MOTHER 8630 HICKORY PLACE, DENTON, MARYLAND, 21629 20a. Method of Disposition 20b. Phace of papersipp (Mame of cemetery crematory or other place) Baltimore, 1 X Burial 2 Cremation 3 Removal from State CHURCH CEMETERY 2011 QUEENSTOWN, MARYLAND 4 Donation 5 Other Specify 21. Signature of Euneral Service License FETIEDOWS GOTHER FENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED the attending physician red for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day 1 Live birth Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy pnor to completion of cause of certificate has page 2 s performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this ٩ 1 V Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification:

After within 24 hours after death. To the Funeral Director: in by the

28a. Date of Injury FOUND: Subject assaulted FOUND 1 Natural 1 Yes 2 ✔ No Pending Apr 27, 2011 0810 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1040 Ruthburg Road, Centreville, MD determined (Specify) found in Field 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCMF O.C.M.E. April 28, 2011 leted cause of death (Item 23a)

Death

Year

State Registrar

Theodore M. King, Jr., MD

Michael Chamberlin 11-03084 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Physician/ Month Day April 22, 2011 2225 hrs Medical Examiner Michael Ravon Chamberlain 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Temple Hills 3334 27th Avenue If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreignWashington Country h Months Day Director 09/21/1993 577-25-7114 1 X M 2 F 17 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f abov injury or other traumatic event, the Medical Examiner must be notified at once. DC Washington None Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3509 Stanton Road SE 20020 USA Funeral 14 Race - American Indian Black 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: Black If Yes, Give Yeer 1 Yes 2 No specify: 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) High Roads Upper Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 11th Sales Clerk School 1 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robin Chamberlain Derek Bullock ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Chamberlain/Mother 3509 Stanton Rd., SE Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 05/02/2011 Landover, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licer 4308 Suitland Road Suitland, MD 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval **Physician** Between Onset and Me dies! Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown signed by the: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Subject shot within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural **FOUND** Pending 1 Yes 2 V No Apr 22, 2011 2208 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3334 27th Avenue, Temple Hills, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the within

31. Date filed (Month, Day, Year)
APR 2 9 2011

Carol Allan, MD

32. Registrar's Signature

ORIGINAL

()av

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

April 23, 2011

State Registrar Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

11-03275		Please Type or Print in Black Indelible Ink. Ensure All C	Conies Are Lee	ible	
Danielle Marie D		State of Maryland / Department of Health and Men	ntal Hygiene	201	1 1559
Physicia Medical Exami	an/		Date of Death Month	Day Year	3. Time of Death 2125 hrs
Miguical Exami	Hei	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	April 29, 20 of Death	4c. County of Death	
		Dorchester General Hospital Cambridge 5 Social Security Number	ler 24Hrs. 8. Date of Birtl	Dorchester	holace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours		601 Foreign	
b		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	1 100		10d. Inside City Limits
id how any ce.	L		mbridge		1 Yes 2 No
the Maryland the Maryland 23a or 28a-f show	Director	10e. Street and Number		g. Citizen of What Coun	try?
tith the 23a or		3450 Twian Bone W 2 6 3 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status	igin? (Specify Yes or No-	USH 14. Race - Americ	ean Indian, Black
or items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican		White, etc.	
ours after atural", caminer	ρ	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		Specify: (1)	11te
136 hin 72 hou e. than "nat edical Exa	letec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT	use retired)	1/2/2/1	Marchal
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other trammatic event, the Medical Examiner must be notified at once	Completed	17. Eather's Name (First, Middle, Last) 18. Mother	r's Name (First, Middle, M	laiden Surneme)	VOIKEA.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	Be	Robert Wheatley Jr. Shi	rley Role	obin Do	wns
MD 21; d 2 should the hand Men n 27 is mar numatic eve	T ₀	19a, Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Num Shirtley Robbin Dougn & Foy 3067 North S	mber or Rural Route Num	ber, City or Town, State,	Zip Code) IMD
re, N s 1 and f Health ff item		20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 an Department of Hes Important: If ite		4 Donation 5 Other Specify: INICA SNOVE CREMATION	5.4.2011	Cambria	lae, mo
Bal permij Depar Impo	Щ	21. Lightquire & Funeral Service Licensee 22. Name and Address of Facility 21. Name and Address of Facility 22. Name and Address of	Stiah St	Campod	as mo
Physician / /Medical		23t. Par I. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as of failure. List only one cause on each line.	cardiac respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
	F	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):			
	mine	cause. Enter Underlying Cause (Disease or injury that initiated			
ecuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be exec physician at the burial - t	dica	UNPENDED AMENDED			
Box 68760 e death certificate b the attending physical d for use as the bu	an/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	ic pregnancy	23d. Date of delivery Month D	ay Year
30x 68 death certifi e attending for use as i	Physicia	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown			
P.O. B es that the de igned by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		bacco use contribute to t	
ords, P.C w requires that s been signed b should be deta	ted t		1 Yes	2 ✔ No 3 Prob	ably 4 Unknown opsy findings available
SCOF te law re te has be	Completed		autops perform 1 ✔ Yes 2	med? death?	ompletion of cause of s
tal Rection The certificate	Be Co	25. Was case referred to medical examiner?		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, 2 140
of Vital Records, ng Physiciao: The law require ther this certificate has been si neral director, page 2 should b	ပ္	examiner? 1 Yes 2 No	Nursing Home 5 1 k? 28d Describe h	Residence 6 Other:	
ion of tending Pheath. tor: After the funeral	tion:	1 Natural 5 Pending Apr 29, 2011 2100 hrs 1 Yes 2 ✓	- Pedestrian s	truck by auto	
Division pital or Attendit ours after death. teral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et	or Town, St	treet and Number or Rur	
		4 Homicide (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla		West of Aireys Road, e(s) and manner as state	
To the Hos within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time, date a	and place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		April 30, 2011	m, ∪ay, rear)
e)		30. Name and address of person who completed cause of death (Item 23a)			
I I		Margarita Korell MD — Assistant Medical Examiner 900 W. Baltimore Street, Ba	altimore, MD 21223	3	

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) April 26 Pay 11:25 P M 2011 **Physician** Μ. Drury Anne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise Assisted Living
5. Social Security Number 6. Sex Howard Columbia
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Ohio 8. Date of Birth (Month Day Year) 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Min 1□M 2**점**F 90 284-14-0594 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinating instituted at 1 ☐ Yes 2 ☐ No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 United States 6500 Freetown Road #201 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White ģ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bahney Margaret Charles McLain ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Columbia, Maryland 21046 10063 Quantrell Lane Susan C. Barshinger/daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hanover, Maryland 04/28/2011 Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licens 4112 Old Columbia Pike Ellicott City, MD 21043 -M00957 uante Ot Thomas 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Urosensis disease or conditic resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cher (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Tes 2 No 1 🔲 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Injury 5 Pending investigation 1X Natural nours after death. neral Director: Aff y filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examines On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D47447 April 27, 2011

20

DHMH 17 Rev 1/2001

State

Registrar

backs

Columbia, Maryland 21046

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andy Lazris

31. Date filed (Month, Day, Year) APR 2 8 2011

6334 Cedar Lane, Suite 103

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dyr, 2915 5-16-11 sm
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato of Ivial y		Sertificate of L		, ,	eg. No. 🤈 🦳 🚶 1	15506
	Physicia	n/	1. Decedent's Name (First, Middle, Las	-	To	n Dov		Date of Deat Month		3. Time of Death O
	Medic	al	4a. Facility Name (if not institution, give	Sandr	a Lee		r Location of Death	May	7, 2011	09:09 A ^M
	Examir	er	100 Greenway, Ap			Perry			Ceci1	
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		221-32-7052 1 1 Usual Residence of Decedent	63 63	Yrs	6.		June 19,	1947 Dela	ware
	and show	tor	10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryl. 28a-f otifiec	Director	Maryland Cec	i1	Perr	yville				1 X Yes 2 No
	h the	al D	10e. Street and Number	-		10f. Zip Code		1	0g. Citizen of What Cou	
	ms 2%	Funeral	100 Greenway, Apt	. 312 12. Was Decedent Ever	in II e	219		noify Von or No	United Star	
036	s after dea ral", or ite Examiner	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🋱 Divorced	Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates.	11 0.3.	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No 		Rican, etc.)	14. Race - Ameri Black, White, Specify:	
5-0	2 hour "natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business In	dustry
121	thin 73	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife	e. DO NOT use retired) TSE			Healthcare	
d 2	Hygie Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)		1144	150	18. Mother's Nam	e (First, Middle, M		
/lan	d be fi Jental Irked Itic ev	임	William Frederick	Yates			Ida Mae	Kelly		
lan	should be n and Ment 7 is marke raumatic		19a. Informant's Name/Relationship (Ty	,					City or Town, State, Zip	
≥	and 2 Health em 27 ther tr		Dawn Day/Daughter 20a. Method of Disposition				-		e, MD 21903	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 4 Donation 5 Other (Specification)	Removal from State //	cemetery, o	sposition (Name of crematory or other place is & Co., Inc	c. May 1	2, 2011	20c. Location - City or To West Chester,	PA
Bal	permit Depar Impor any in		21. Signa are of Funeral Service Licens	. Hickory		22. Name and Addre	^{ss of Facility} Hic ockton St	ks Home ., Elkto	for Funeral	ls, P.A. 21
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Medical Examiner Sequentially list conditions.										Approximate Interval Between Onset and Death
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a cor	nsequence of):	ens/or				
8760	ificate be executed ig physician and as the burial-transit	Medical E	resulting in death) Last	Due to (or as a condition of the conditi	nsequence of):	s Ty	PE II			
Ö	Attending Physician: The law requires that the death certificate be executed at death. The death certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	sy		23d. Date of deliv Month	rery Day Year
Division of Vital Records, P.O. Box	v requires that the second speed by should be detailed.	by	Part II. Other significant conditions of MORSIA	ontributing to death but no	ot resulting in the	ne underlying cause giv	ven in Part I.	23e. Did tob	es 2 No 3 Pro	he cause of death?
ord	v requ	Completed	HYPER	CHOLEST	ERO	EMIA		24a. Was ar	24b. Were auto	psy findings available
3ec	he lav ite has	mo	DEGEN	ERATIV	EC	STECA	RMIT	autops perform		mpletion of cause of
al	rsician: The law is certificate has b	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Checi		TE 165	2010
Σ	Physic this ce ral dire	욘	1 ☐ Yes 2 🔀 No			tient 3 DOA Oth	4 LI Nursing Ho		nce 6 Other (Specifi	()
D 0	ding F h. After i funera	ate	27. Manper of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Yea	ar) 28b. Time injur	y work		28d. Describe ho	w injury occurred	
isio	or Attending Physician: The la after death. Director: After this certificate h i in by the funeral director, page	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				ies Z L No	28f. Location (Str City or Town,	reet and Number or Rura , State)	i Route Number,
ă	pital o		1 No. 114 in Ph.	lainer To the best of sect		Ab				
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L Medical Examination	ician: To the best of my liner: On the basis of examile Practioner: To the best	nation and/or in	vestigation, in my opinio	on, death occurred at	t the time, date and	d place, and due to the ca	iuse(s) and manner stated.
_	Vithi Comp		29b. Signature and title of certifier	,		29c. License	number	25	9d. Date signed (Month,	Day, Year)
D	13 3th			azaz M			043-87		05.09.	
	V		. 200	PLES PL	(Item 23a) (Typ	e, Print) Sn A SO	J W.	EVAR	KAE	19702
	Stat Registra	G	31. Date filed (Month, Day, Year)	32. Registrar's S	orgnature M	Y 1 6 2011	Beneva	p. 4	arked	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) John B. Evans 2. Date of Death 3. Time of Death 11 pay Physician/ April 3:03P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Royal Care Adult Facility Fort Washington 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours June Day 1 🕱 M 2 🗆 F 1919 Georgia Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Oc. City, Town or Location
Washington 10b. County with the Maryland Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 817 Chesapeake Street Southeast 20032 Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Agned Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc.
.. Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₹ Widowed 4 ☐ Divorced "natural", Completed Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "naturury or other traumatic event, the Medical I ury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Administrator (Specify only highest grade completed) 2+ College (1-4 or 5+) Elementary/Seconday (0-12) Greater SE Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Monts 17. Father's Name (First, Middle, Last) John Evans | 19a. Informant's Name/Relationship (Type, Print) | Brenda Ford / Niece 10 Anderson Avenue Sanford, FL 32991 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale Crematory 20c. Location - City or Town, State Riverdale, MD 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 04/1972011 1 Burial 2 S Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Dunn&Sons 5635 Eads St. NE Washington, DC Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, Examine Due to (bride a cur sequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Adult Care examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who completed of Bernice D. Jackson

32. Registrar's Signature back 29c. License number

MD17118

npleted cause of death (Item 23a) (Type, Print) son M.D. 1160 Varnum St. NE Washington, DC 20017

29d. Date signed (Month, Day, Year)

04/28/2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Item 25 per med cert G915 57 17/17 dk
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate of Ivial ylan		tificate of L			Reg. No.2	1 15	598
		,	Decedent's Name (First, Middle, Las	t)				2. Date of Dea	th	3. Time of	Death
	Physicia Medio		Robert Frederi		ourn			April	28, 2011	6:35	рм
4	Examin		4a. Facility Name (if not institution, give 28376 Old Eden	Road		Eden	r Location of Death		4c. County of Somer	rset	
	Funeral Director		217 30 4332	7. Age (In yrs. la 70	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/16/		9. Birthplace (State o Country) Maryland	r Foreign
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside Ci	ty Limits
	larylar 3a-f s iified	Director	Maryland Somers	et	Eden					1 ☐ Yes	2 🕱 No
	the M		10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?	
	h with 1s 23a nust b	Funeral	28376 Old Eden			218			USA		
	r deat rriten iner r		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	city Yes or No- Rican, etc.)		American Indian, White, etc.	
980	s after ral", o Exam	d by	3 ☐ Widowed 4 🛣 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Army Year or Dates.	1	☐ Yes 2 🗷 No	Specify:		Specify:	white	
21215-0036	natu "natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	Give F	ent's Usual Occup	during most of worki	ng I	16b. Kind of Busin	ness Industry	
121	thin 77	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	1	life. DO NOT use retired) Truck Driver			Conc	crete	
	led wi Hygie other ent, ti	6)	17. Father's Name (First, Middle, Last)		1 110	ICH DETVC	18. Mother's Name	e (First, Middle,		2000	
<u>rlan</u>	d be fi dental arked itic ev	욘	Robert Fisher El	burn			Mary	Ruth Ca	lliuaill		
Maryland			19a. Informant's Name/Relationship (7) Robert Elburn/sc		19b. Mailin 143	g Address (Street B28 Bucha	and Number or Rura nan Trail	Route Number	; City or Town, Stat Lot 22, Wa	te, Zip Code) aynesboro	7 17 268
Baltimore.	of He of He lf item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Barroyal from State	emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - Ci	ity or Town, State	
Ë	: Page tment tant: I		4 X Depation_5 ☐ Other (Special				istry 4/29		Hanover		
Bal	permit Depar Impor any in		21. gnature (Fuperal Section) ico	ee	5	01 Snow	Hill Rd.,	Salisb	ury, MD 2	l Associat 21804	ion
4	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to it as a consequent	beel	or the mode of dyir	ig, such as cardiac C	respiratory arr		Approximat Interval Bet Onset and I	ween
	p #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	uence of):						
	ecuter and I-trans	Examiner	Cause (Disease or lining) that initiated events resulting in death) Last Due to (or as a consequence of):								
0	cate be executed physician and the burial-transit	Medical	<u> </u>								
8760	ificate ig phy as the	Medi	S Institute								
Box 6	death cert he attendir hed for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 Live Birth 2 Fet: 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnan Other (specify)	су		23d. Date Monti	of delivery h Day	Year
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	v requires that it is been signed be should be deta	ed b	FOOT Grang	reve				1 🗆		Probably 4 🗆	
Records.	aw rec as bee	Completed by	Kenal Fo	ilue				24a. Was autor	osy pri	ere autopsy findings or to completion of c ath?	available cause of
	Physician: The law this certificate has al director, page 2			-				1Yes	nmed de: 2 No 1	Yes 2 🗆	
Vital	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	L ED/O: ++:	Oth	Place of Death (Checiner:	_/	dance 6 Othor	(Cassiful	
o ç	g Physer this eral di	e: 10	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju	ry at		dence 6 Other occurred		
	ending sath. or: Aftu he fun	ficat	1 Natural 5 Pending 2 Accident Investigatio	n	injury	M 1 🗆	Yes 2 No				
Division	al or Attendi s after death. I Director: A d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	Street and Number (vn, State)	or Rural Route Numi	ber,
3 🗖	Hospil 24 hour Funera	Medical	(Check Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of m	n and/or invest	tigation, in my opin	ion, death occurred a	t the time, date a	and place, and due to	o the cause(s) and ma	anner stated
2	To the within To the comple	Σ	20b. Signature and title of certifier		iy italowloogo, i	29c. Licens			29d. Date signed (
* a		(A) (le		MI	Da	2627	8	4-2	8-11	
7	IM		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, F	orint)	PU BU)	< 1 7 33	Solls.	L, MD.	2/80
	Sta		31. Date filed (Month, Day, Year) APR 29 2	32. Registrar's Signa	ature.	a. N. J			()	
	Registr	ar	ALU MA C	VIII pomo	10. 10	acres					

Please Type or Print in Black Indelible Indelible Indelible. Finsyng All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 7:30 AM **Physician** Theodore J. Felton pril 26 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Princess Anne Somerset Manor Manokin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5-25-1939 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Vrs VA 229-46-0177 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Modicel Examiner must be notified at once. 1 LaYes 2 □ No Director MD Somerset Princess Anne 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 11974 Edgehill 21853 USA Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married SpecBlack Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clam Shucker Seafood Industries 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Edward W. Felton Leonia Cates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Juanita Demby/Daughter 110 Kennedy Drive, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Crematory, 5-6-2011 bover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 917 W. Isabella St. Bennie Smith 21. Signature of Funeral Service Licensee Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 54 cars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760, Physician/Medical attending ph I for use as th IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. detached □Yes 2□No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2. No Other: Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral (28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number inhe not April 26th 2011 0051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 - S. DIVISION ST, SALISBURY, MD 21804 NATESAN DK. USITA 31. Date filed (Month, Day, Year) APR 28 2011

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edward Raymond Gamberg P M 26, Apri] 2011 2:28 Medical 4a Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park 484 London Lane Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 91 Months Min (Month, Day, Year) 1920 South Dakota 1 🕱 M 2 🗆 F Hours 503-16-8066 Vrs Director Usual Residence of Deceden 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Examiner must be notified MD Anne Arundel Severna Park 1 Yes 2 X No ő 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 21146 USA 484 London Lane items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc "natural", or þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Director C 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Metallurgical Research & Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Olga Norin Harry Chester Gamberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Point Road Seneca, SC 29672 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is a Robert Gamberg / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 29 2011 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Coronary Atherosclerosis To the Hospital or Attending Physician: The law requires that the death certificate be executed Exal and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yea Month Day Pregnant at time of death Yes 2 No the 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🔀 No Other: within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dir မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)



ÄPR 2 9 2011 Registrar

Charles E. Rackley

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

Registrar's Signature parke

MD 25936

Georgetown Medical Center Washington, DC 20007

4-28-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23pt. II per doc g916 6-29-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Jack Hutchins 2:13 Medical April 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital <u>Clinton</u> Prince George's Social Security Number If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Year If Under 24 Hrs. **Funeral** Days 1 🖵 M 2 🗆 F Months Hours Director 428 32 7425 Oct 16, Jackson. 1926 Miss Usual Residence of Deceder show 10a. State the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland Prince George's 1 🗆 Yes 2 🔀 No Upper Marlboro 10e. Street and Numbe rms 23a or 9 10f. Zip Code 10g. Citizen of What Country? Funeral 9920 Rosaryville Road 20772 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 ☐ No If Yes, Give Year or Dates. "natural", or iten ledical Examiner r 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WII 1 ☐ Yes 2XXNo Specify Completed 3 Widowed 4 Divorced Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Technician Owner of Health and Mental Hyg item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jules Hutchins Vera Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Hutchins (Wife) 9920 Rosaryville Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H
Important: If ite
any injury or oth 20c, Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery May 2, 2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 1001 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Day Year Pregnant at time of death the 9 Unknown Unknown ed by t signed t significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [≥ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been Maldenstrom Macroglobulinemia Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy B-Cell Lymphoplasmacytic Lymphoma perforn certificate 1 Yes 2 No Yes Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of hin 24 hours after death.

the Funeral Director: After
pleted filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 🗌 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CENTER WALDENT ALC. completed cause of death (Item 23a) (Type, Print) CU Wan 120 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3-20 Pay 12:58p M Christine Harrell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Mountgomery Takoma Park If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🌣 F 66 Hours 8-26-1 944 North Carolina Director 244-80-4691 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 x Yes 2 No Prince Georges Mount Ranier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2704 Webster Street Apt. 20712 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖺 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management System SPE. DC Government æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kemp Lee OTelia Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Harrell/Husband 2704 Webster Street MT. Ranier MD. 20712 Apt. 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from 4-30-2011 5 🗌 Other (Sr on Hill Baptist Littleton, NC Signatu 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death mmediate Cause (Final ROINTESTINA Trysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 204M Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Dauss (Disease or iinjur use as the burial-transi OTH and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician; page 2 should be detached for use as the burial Physician/Medical BMDC Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Yes 2 - No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate ! 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate; To 1 Department 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed caus

31. Date filed (Month, Day, Year) MAY 0 2 2011 death (Item 23a) (Type, Print)

32: Registra s Signat

JNK UNK State of Maryland / Department of Health and Mental Hygiene									
		Registrar Certificate of De		g. No. 4	1560;				
Physic Medical Exan		FARIBORZ HEDAYAT		2. Date of Death Month April 25, 20		3. Time of Death 0905 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. Cit	ty, Town, or Location of Dea nham		4c. County of Death Prince George				
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt				
Directo		378 32 4594 1X M 2 F 74 Yrs.	onths Days Hours Mi	Min. Feb 22 1937 Country Iran					
Any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
* .	ة	Md Prince George Lapham				1 X Yes 2 No			
Maryl 28a-1 d at o	Director	10e. Street and Number 10f.	Zip Code	100	g. Citizen of What Coun	itry?			
with the Maryland ms 23a or 28a-f sho		6931 Cipriano Woods Court	20706		U.S.	Α.			
ath will terms ?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Marital Status 15. Was Decedent Ever in U.S. 16. Marital Status	edent of Hispanic Origin? (& ecify Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,			
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10g. Citized 11g. Mag. Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Yes, 2g. No specify: 11g. Yes									
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Baltimore, ME permit. Pages 1 and 2 s Department of Heath as Important: If item 27 injury or other traums		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Noteromatory or other place)	lame of cemetery,		20c. Location - City or 1				
Baltimore, permit. Pages I as Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: Maryland Na	ational 5/	5/2011	Laurel, N	1d			
Balti Permit. Departn Import		21. Signat f Funeral Service-Licens 22. Name at	nd Address of Facility Ha	11 Brot	hers Fune	ral Home			
	<u> </u>	1 / 2004 C. Marth 1021 F	lorida Ave	NW .	Wash D.C.	20001			
Physician /Medical	Between								
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	_	Sequentially list conditions, b							
	<u>=</u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
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760, ficate be ex g physician the burial	led.	AMENDED 23a,27,28a-f,g915 IF FEMALE: 23c. If yes, outcome of pregnancy	5-17-11 sm		23d. Date of delivery				
68760, certificate b nding physic se as the bur	ian/Me	23b. Was decedent pregnant in the past 12 months?	th 3 Ectopic pregna	ancy	Month Da	зу Үеаг			
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of Vital Records, ng Physician: The law require the certificate has been si neral director, page 2 should t	Completed			24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of			
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Vital ysician his cert director	Be	25. Was case referred to medical examiner? 1	26.Place of Death (Check DOA Other4 Nursin		esidence 6 🗸 Other:				
ing Physical After this funeral dir	1: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe hov		Scene			
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ospital hours ineral	is a set of the first of the fi								
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the companient of th	ne time, date and place, and ny opinion, death occurred a	I due to the cause(s at the time, date and	s) and manner as stated d place, and due to the	cause(s)			
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)									
		/ Calpenn	O.C.M.E.	1.	April 26, 2011				
0		30. Nau and address of person who compiled cause of death (Item 23a)							
C	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
St Regist		31. Date filed (Month, Day Year) 32. Registrar's Signiture							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HADASEL 2011 W. HILL APRII 2:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. THOMAS MORE NURSING HOME HYATTSVILLE PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours DEC 28 VIRGINIA **Director** 579-34-1439 Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f sho must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD PRINCE GEORGE'S HYATTSVILLE ۵ 10e. Street and Number 10g. Citizen of What Country? Funeral 4922 LASALLE ROAD 20782 USA , or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status nit. Page 1 and 2 should be filed within 72 hours after dea arternor of Health and Mental Hygiene. ordenst. If item 27 is marked other than "natural", or iten grounds or other traumatic event, the Medical Examines. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Completed 3 Divorced 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 SECURITY SPECALTIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever 2 OAKLEY WILSON PAULIDA POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVONNE PARKER/NIECE 7010 97th AVENUE LANHAM, MARYLAND 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATIONAL CEMETERY 4/29/11 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician/ disease or condition resulting in death) ASCULAR en no Medical Due to (or as a consequence of): **Examiner** Candisvasular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 use as If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months?
1 Yes 2 XNo Month been signed by the a should be detached Yes _ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available page 2 autopsy prior to completion of cause of performed? Yes 2 No Usteoporosis death? To the Hospital or Attending Proyston......within 24 hours after death.

To the Funeral Director. After this certificate this certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
APR 2 9 2011

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

sarks

0185

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ON 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) Funeral Months Hours 0970371947 216-46-8887 Maryland 63 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location aţ death with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🏻 No Wicomico Salisbury Maryland 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? ò items 23a Funeral 21804 USA 31400 Spearin Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify white 3 Widowed 4 X Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traimasts. Elementary/Seconday (0-12) College (1-4 or 5+) Public Education 12 Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Virginia Lucille Johns James Lester Askey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2158 Southwest 18th Terrace, Gresham, OR 97080 Brian C. Hollenbach/son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Salisbury Crematory 1 Burial 2X Cremation 3 Removal from State 4/30/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph i ian/ disease or condition Medical resulting in death) sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or es a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 N Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ER/Outpatient 3 DOA မ patient 2 27. Manner death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending 2 🗌 No hours after death. 1 Yes Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Skaminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 7, Physician/ Year Edna Catherine Virginia Hooper 2011 A M 1:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-46-1934 1 🗆 M 2 🔀 F Months Days Hours 85 January 24, 1926 Maryland Director Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21701 United States of America 560 East Church Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ 2 XNo Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 Edward L. Umberger Edna Marie Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hooper / Son 560 East Church Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Resthaven Memorial Gardens May 11, 2011 1 A Burial 2 Cremation 3 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Sen Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ementa Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) the (detached 9 Unknown 9 Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chitestrilemia 1 Yes 2 No 3 Probably 4 Wunknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 death? 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this in by the funeral 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 24 hours after death. Funeral Director: A 2 🔲 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined pleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certified 29d. Date signed (Month.

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State Registrar Name and address of person who co

Pauline Jane Brown Hahan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certific	cate of L	Death			g. No.	
Physician/ Medical Examiner	Decedent's Name (First, Midden Paul	^{He,Last)} Pauli i	ne Jane B Hahn	rown H	ahn		Date of Death Month March 12,	Day Year	3. Time of Death 1331 hrs
	4a. Facility Name (if not institution 13215Greenburg Rd-				. City, Town, or Lo Smithsburg	ocation of Death	1	4c. County o Washing	
Funeral Director	5. Social Security Number 216-38-2446		7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24Hrs Hours Min		6,1922	9. Birthplace (State or Foreign CountryMary]and
ow any	Usual Residence of Decedent 10a. State 10b. County Md. Wash		10c. City, Tow	n or Location					10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number 13215 Greens		3111		10f. Zip Code 217		10	g. Citizen of What	
er death with , or items 23 r. must be no	11. Marital Status 1 Never Married 2 N		edent Ever in U.S. rces?	If Yes	Decedent of Hispa i, specify Cuban, I			14. Race White Specify:	American Indian, Black, etc. White
5-0036 ed within 72 hours afti tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	ecify only highest grade		during mos	Usual Occupation of working life. C			16b. Kind of Bus	ting Co.
1215-0036 be filed within 7 with Hygiene. raked other than cent, the Medica	17. Father's Name (First, Middle Charles Wac	chter Brown				Esth	er Bland	i McGlau	ghlin
MD 21() 12 should b th and Men 127 is mar umatic eve	19a. Informant's Name/Relations J. Michael Hah			22233	Durberry	Rd. Sm	i thsburg	,Md. 21	
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition 1 Description 2 Cremation Donation 5 Other S	Specify:	m State crem	atory or othe	metery	Mar 20	ch 17,	Casca	de, Md.
	21. Signature of Funeral Service Licensee M01414 J.L. Davis Funeral Home Smithsburg, M.								
Physician Ēxaminer	25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease a. Atherosclerotic Cardiovascular Disease								
- -	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b	consequence of):						
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last	C	consequence of):						
7760, ficate be executed g physician and s the burial - transit	UNPENDED	d AMENDED						-	
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 ✔ No 9 Un	the 1 Live bi	ant at time of death	2 Feta	death 3	Ectopic pregna	ancy	23d. Date of Month	delivery Day Year
P.O. B s that the dagged by the eletached is detached by Phy	Part II. Other significant condi		death but not resulti	ing in the un	derlying cause giv	en in Part I			bute to the cause of death? Probably 4 ✔ Unknown
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician.	Breast Cancer						24a. Was a autops	n 24b. V	Were autopsy findings available rior to completion of cause of eath?
tal Reccian: The lace certificate hector, page Be Com	25. Was case referred to medical					of Death (Check	1 Yes 2	No 1	Yes 2 No
F Vita Physici or this or al direc	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir		Outpatient		other Nursi		Residence 6	
ion of tending P eath. tor: After the funera		28a. Date of (Month, estigation	of Injury 28b Day,Year)	. Time of Inj		at Work?	28d. Describe h	ow injury occurre	ed
Division o spital or Attending nours after death. near after death. filled in by the fune Certification:	3 Suicide 6 Cou		of Injury - At home,	farm, street,	factory, office but	ilding, etc.	28f. Location (S or Town, St		er or Rural Route Number, City
To the Host within 24 ho To the Func completely f		Physician: To the best aminer:On the basis of and manner st	f examination and/or						
H 3 H 2	29b. Signature and title of certifi		100		29c. License O.C.M			29d. Date signe March 14, 2	ed (Month, Day, Year)
Д	30. Name and address of person Russell Alexander MI		of death (Item 23a edical Examine		Penn Street, E	Baltimore, M	D 21201	<u> </u>	
State Registrar	31. Date filed (Month, Day, Year,		gistur's Signature	4	OCA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per Phy G915 / 16/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Clifford 1 Marshall Henderson 7:05a ™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Genesis Layhill Center Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min. 540-05-5808 1492344919 Oferon 91 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 14400 Homecrest Road #45 USA Was Decedent Ever in U.S. Armed Forces? 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? 1942 12 Yes 2 No 1946 Black, White, etc. þ 1 Never Married 2 X Married White 1 ☐ Yes 2 🖾 No Specify: Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gov't Postal Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Edna Ohlegschlager Robert M.Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Briggs Court Silver Spring, Md. 20906 Marshall Henderson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Chesapeake Crem. 4/18/2011 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specifing Signature of Funeral Service Lic PHIETPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical

Division of Vital Records, P.O. Box 68760

and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

show

Baltimore, Maryland 21215-0036

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of

29c. License number

D0064208

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) April 18,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saadia Husain M.D 3227 Bel Pre Road Silver Spring, Md 20906

State Registrar

7

29a. Certifier

(Check

31. Date filed (Month, Day, Year) 21 APR

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 2^{Day} 2011 Physician/ IRVING APRIL Μ. 2:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 2018 FORESTDALE DRIVE SILVER SPRING 8. Date of Birth (Month, Day, NOV • 19 Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days Min 1 M 2 XF Hours 1936 WASHINGTON, DC **Director** 579-52-3046 74 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location with the Maryland at Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 □ No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 2018 FORESTDALE DRIVE 20903 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr. any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 4 REGISTERED NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN G. BAILEY WILLIE A. WHITE 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5701 37th AVENUE HYATTSVILLE, MARYLAND 20782 PATRICIA GREEN/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 5/6/2011 SUITLAND, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Bruns 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) METASTATIC BREAST CANCER Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) nours after death.

neral Director: After this or
I filled in by the funeral dire 1 Tyes 2 🔀 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 \square Pending work?
1 Yes 2 No M Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tpleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practionel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifiq 29c. License numbe 29d. Date signed (Month, Day, Year) MD FEO APRIL 28, 2011

31. Date filed (Month, Day, Year MAY 0 2 2011

YIN NAING M.D. 1160 VARMUN STREET N.E. SUITE 318 WASHINGTON, DC 20017 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

State

Registrar

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of
Division of Vital Record	To the Hospital or Attending Physician: The law requir within 24 hours after death.	To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should

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Funeral Director		220-32-4833	ex 7. Age (In 62	yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	Cour	place (State or Foreign htry) yland
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h with	a D	520 S. Main St.,	Apt. 119		21901			Unit	ted Stat	es
death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe In, Mexican, Puerto I	ecify Yes or No		4. Race - Americ	can Indian,
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es 1 s		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐	Removal from State	0b. Place of Disp cemetery, cre	osition (Name of ematory or other place	e) May	ate 13	20c. Loc	ation - City or To	own, State
Pag ment ant: I		4 Donation 5 Other (Specif	Removal from State	R.A. Fe	rris & Co	., Inc. 2(011		t Cheste	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, its Mudical once.		21. Signature of Funeral Service Licer	see	I .	2. Name and Addres					•
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hysic his ce		1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Othe	er: 4 🖫 Nursing Hon	ne 5∐ Resi	dence 6	□Other (Specia	fy)
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25		30. Name and address of person who			, Print)		1			
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Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistrar's S	al a a						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24, Day 2011 Year Leal S. Jones 9:56 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Ctr. Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 9, 1932 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Hours 78 **Director** 579-52-2941 Tennessee Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. The fire 27 is anaked other than "natural", or items 23a or 28a-f shour I filem 27 is anaked other than "natural", or items 5aa or 28a-f shour or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington D.C. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 266 Division Avenue, N.E. U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Maritai Status 14. Race - American Indian. African-American 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lieutenant Sturghill Lyda Edmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Mitchum-Daughter 1406 Edgewick Ave., Capitol Hghts, MD 20743 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Apr. 30, 2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemtery Signature of Funeral Service Licensee 2. Name and Address of Facility 2504 28th St., N.E., Bonnette & Asoc. Funeral Home 20018 22, Name and Address of Facility a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Hypertensive Cardiovascular Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be Admontated. base been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Brain neoplasm-unspecified 1 Yes 2 No 3 Probably Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: ဂ္ဂ 1 🗌 Yes 2 🗆 KNo Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 26, 2011 MD30564 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 2 9 2011 April 32. Registrar's Signature

Anthony Ibe, MD

DHMH 17 Rev 7/2009

1160 Varnum St., N.E., Washington, D.C. 20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JACKSON APRIL 2011 6:18 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Oxon Hill 123 Cree Drive . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Date of Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Hours Year) 9<u>60</u> **Director** 231-11-7385 50 Nov. VA Usual Residence of Decedent 28a-f show 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 K No Prince Georges Oxon Hill ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 123 Cree Drive USA 20745 "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No 3 Widowed 4 Divorced Completed Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12th District Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Jackson Connie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Devin Claynisha Jackson-Daughter 123 Cree drive Oxon Hill, Md. 20745 permit. Page 1 and 2 Department of Healt Important: If item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State Date □ Burial 2 ☑ Cremation 3 □ Removal from State Metropolitan Crematory 4-29-2011 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 'n 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 2 □ No 3 □ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🔼 No certificate has page 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury death. Accident Investigation filled in by the 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Tractioner: To the best of my knowledge of at the time cast and place, and one to the cause(s) and manner stated Certifying Number Tractioner: To the best of my knowledge of at the time cast and place, and one to the cause(s) and manner stated (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amamam 4-27-2011 MD035067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepa Subramaniam, MD 3800 Reservoir AveNW Washington, DC 20037 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Koslak Mary April 27 11:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suitland 6006 Maria Ave Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 22. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Days 157 16 1830 New Jersey 86 Director Usual Residence of Decedent show 10a, State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Ves 2 No Prince George's Suitland Maryland 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20746 6006 Maria Ave United States items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 \square Yes 2 $\prod_{\mathbf{X}}$ No Specify: Completed White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guidon (George) Reut Barbara Gersztyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald F. Koslak (Son) 144 West Thomson Drive, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/3/2011 Resurrection Cemetery Clinton, MD of Funeral Service Licensee Signatur 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Ppr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Bladder Physician/ Meta Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Examiner Divide for as a consequence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0045 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) niner Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 1 Yes Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a, Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) Mer MD64153 April 29, 2011 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 238 Jose Mendoza, M.D. 8926 Woodyard Road Suite 101, Clinton, MD 20735 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

#23a&23PII Per PHY G915 5/1//2011 JH

State of Maryland / Department of Health and Mental Hygiene

&23e for State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 April 20 6:20 Рм Jestyne C. King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hyattsville Thomas Medical Complex 9. Birthplace (State or Foreign Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Nov. 13, Year) 932 1 M 2 X F Months Hours Min. OKTahoma **Director** 78 577-44-9159 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Fort Washington 1 X Yes 2 No Maryland Prince George's 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20744 9107 Pinehurst Drive items death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō 1 Never Married 2 Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Nidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lonnie Lee Rowland Ruby Overall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9107 Pinehurst Drive Fort Washington, Md. 20744 Freda C. King - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 本Burial 2 ☐ Cremation 3 ☐ Removal from State April 29, 4 Donation 5 Other (Specify) Maryland National Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Road NE Washington, DC Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate y Etanyal Between Onset and Death Carcinoma Lung Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consectioned on that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Records, structure 2 1 Probably 4 Unknown 1 🗌 Yes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed The Ventilator Dependent 1 Yes 2 No 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA မ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined the Hospital Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) DO 1852 30. Name and address of person completed cause of death (Item 23a) (Type, Print) veenshiry Rel VORE MDY 31. Date filed (Month, Day, Year)
APR 2 a 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#7, 8, 10b, 10c State of Maryland / Department of Health and Mental Hygiene State 10d per FH 4/29/2011 CMH Registrar AACO Health Dept. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P. LORENZET LEO 22:04M 04 7 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 4000 SAMARITAN HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9/21/1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Min. PENNSYLVANIA -90 Yrs. Director 212-18-4092 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norther once. 10b. County Baltimore Whitemarsh 10a. State 10c City Town or Location 10d. Inside City Limits Director 1 XYes 2 XNo BALTIMORE MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21234 2907 ANDORRA CT. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 1942— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1946 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 BRICK MASON CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 PIETRO LORENZET LUCY DINARDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2907 ANDORRA CT. APT. C, BALTIMORE, MD 21234 PHILOMENA LORENZET/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 05/03/2011 STEVENSVILLE, MD 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELFENBEIN ENEWNAM CREMATION & FUNERAL CARE, P.A. 814 BESTGATE ROAD, ANNAPOLIS, MD 21401 21. Signature of Funeral Service Licenses enere 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician/ Aortic Stenosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ulmonary disease hronic obstruc Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) and that initiated events resulting in death) Last the attending physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by I should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by Aspentas exposure, Hypertensian. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an branch after death.

Director: After this certificate has autopsv performed 1 Yes No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes မှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicines To the best of my knowledge, death occurred at the time. Sales and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D RES 000 4/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCK RAVEN BLVD, BALTIMORE, MD 21239 TIM2LSINA SULAJ

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) APR 2 9 2011

32. Revistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MATRIL Physician/ 27 201 Year 00:55 A м LOOPER GLORIA Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death PRINCE GEORGE'S CLINTON HOSPITAL SOUTHERN MARYLAND Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 X F WASHINGTON, DC 578-68-0891 60 Ĩ951 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No MD PRINCE GEORGE'S FT. WASHINGTON ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n Funeral 20744 USA 8218 BARRETT ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Non "natural", or item edical Examiner n Was Deceue... Armed Forces? Ves 2 X No 14 Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced þ Maryland 21215-0036 within 72 hours after BLACK If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene.
27 is marked other than "
r traumatic event, the Med life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CUSTOMER SERVICE PRIVATE Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evennes. 2 ELBA MATTHEWS JAMES COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1311 FATIMA PLACE HYATTSVILLE, MARYLAND 20785 DENNIS LOOPER/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 5/6/2011 WASHINGTON, DC GLENWOOD CEMETERY 4 Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 unler 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the at Id be detached fo 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Hanknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy certificate 1 Yes 2 No Yes 25 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မြ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 124 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 2 🗌 No Accident M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determinud City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exa Certifying Nurse Practioner: To the b mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only o 29h. Signature and 29c. License number e of death (Item 23a) (Type, Print) Name and address 23 32, Regist Date filed (Mo State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Linwood Lawrence April 2011 2040 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. (Month, Day, Year) 1 🕱 M 2 🗆 F Director 240-54-0565 NC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti if item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD PGOxon Hill 10e. Street and Number 10g. Citizen of What Country? Funeral 20745 521 Wilson Bridge Drive #A1 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Weldon Florence Joe Lawrence 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Musicmaster Drive ilver Spring, MD 20904 Quianna Lawrence/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Hill Cemetery 4/30/11 Cedar Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Pay 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a:

To the Funeral D

completed filled in Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred whe time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number DOOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Carroll

7600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certifica	ent of Health and Mental H te of Death	Reg. No.	9
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) DOROTHY E. LEWIS-GRAY		2. Date of Death Month Day Year April 23, 2011 3. Time of Death 0044 hrs	
	4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center	4b. City, Town, or Location of Death Cheverly	h 4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 M 2 F 47	day) If Under 1 Year If Under 24Hrs Months Days Hours Mir		
the Maryland a or 28a-f show any tified at once. Director	Usual Residence of Decedent		10d. Inside City Limits 1 X Yes 2 No.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, 2 No If Yes, Give Year or Dates:	2 0 7 4 6 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:	Specify: BLACK	
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natu c event, the Medical Exam To Be Completed		ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use ret HOMEMAKER 18.Mother's Name		_
MD 21215 ad 2 should be file and and an arked a aumatic event, f		Mailing Address (Street and Number or	LEWIS Rural Route Number, City or Town, State, Zip Code) 03 SUITLAND, MARYLAND 20746	_
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other fraur	20a. Method of Disposition 20b. Place of cremator 3 Removal from State	Disposition (Name of cemetery, ry or other place) DALE CREMATORY 4/2 22. Name and Address of Facility J	Date 20c. Location - City or Town, State 8/11 RIVERDALE, MARYLAND B. JENKINS DUNERAL HOME, INC. D HYATTSVILLE, MARYLAND 20785	
Physician Medican Examiner	23a. Part I. Eller the disease, or complications that caused the death. Do not failure. List only (one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			al
O, e be executed sysician and burial - transit	(Disease or i. jury that initiated events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED			
). Box 68760, the death certificate be executed to the attending physician and ched for use as the burial - transi Physician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	23d. Date of delivery ancy Month Day Year	
Division of Vital Records, P.O. Box 6876. To the Boupital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/M.	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	е
of Vital Rec ng Physician: The After this certificate aneral director, page n: To Be Con	Tes 2 No	26.Place of Death (Check patient 3 DOA Other Mursing me of Injury 28c. Injury at Work?	1 ✓ Yes 2 No 1 ✓ Yes 2 No only one) ng Home 5 Residence 6 Other: 28d Describe how injury occurred	
Division o Boptial or Attending 24 hours after death. Funeral Director: Aftered in by the funeral of the funeral of the funeral of the funeral Certification:	1 Natural 5 Pending Apr 22, 2011 Apr 2354 2 ✓ Accident Investigation	hrs 1 Yes 2 No	Pedestrian struck by auto 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pennsylvania Ave @ Donnell Drive, Forestville, MD	,
To the Hospital within 24 hours To the Functual completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated. 29b. Signature and title of certifier/			
2	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	April 24, 2011	
State Registrar	Victor Weedn MD JD Assistant Medical Examiner S 31. Date filed (Month Day, Year) A PR 2 9 2011 A PR 2 9 2011	900 W. Baltimore Street, Baltimo	ore, MD 21223	

OCME

	d 206 pa Health) t. 5 <u>-</u> 10-11 K	Plea AH	se Type o Amen State	r Prin d It of Ma	it in B arylanc	l <mark>ack l</mark> d / Depa	Heli artme	ole Inl ent of F	∲:1579 Health	पृष्ट्य and N	II Copie Iental Hy	s A gier	r <mark>e Leg</mark> ne	ible.	
			State Registrar							te of L				Reg.	α	Contractions (In-Utilities	15620
	- ·	,	1. Decedent's Nam	e (First, Middle,	Last)								2. Date of De	eath			3. Time of Death
	Physic Med		John B.	Miller,	Jr.								April	23,	2011	Year	2:00 A M
	Exam		4a. Facility Name (if		•	mber)			4b. Cit	y, Town, o	r Location	of Death		- 1	4c. County		
		м	Laurel Re						Lau						Prince		
	Funera Directo		5. Social Security N 578–42–773	6	6. Sex 1	_	(In yrs. las 78	t birthday) Yrs.	Month:	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Novembe	rth ay, Yea 1 4,	^{r)} 1932	9. Birth	nplace (State or Foreign Ifornia
	how how	=	Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation								10d. Inside City Limits
	aryla a-fs ified	Director	Maryland	Prince (Georges		Laur	e1									1 ☐ Yes 2 🛣 No
	he M or 28	ļ	10e. Street and Nur	nber					10f. Z	ip Code			_	10a.	Citizen of V	Vhat Cou	untry?
	with t	Funeral	6915 Fitz	matrick I	Drive				20	0707				US			
	eath tems	Ļ	11. Marital Status	·post-root	12. Was Dec	edent Ev	er in U.S.	13. V	_		ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		_	e - Ameri	ican Indian,
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any one.	ed by	1 ☐ Never Marr 3 ☐ Widowed		Armed Fried 1 X Yes If Yes, Gi Year or D	2 🗌 N	5-85				Specify:		Rican, etc.)		Specify:	k, White Wh	, etc. ite
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Baltimore,	ge 1 nt of : If it		1 🛣 Burial 2	☐ Cremation	3 Removal from	n State	cer	metery, cren	natory or	other place	;e)	Sept.	7,2011 - unk	20c	Location -	-	
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Bal	perm Depa Impo any il		21. Signature of Fu	neral Service Li	wivs	4		22 F]	. Name a	and Addres	ss of Facilit 1 Home	. INC					
			23a. Part 1. Enter t				the death	Do not ente	01 S	andy S	pring	Rd.,	Laurel,	Mary	land 20	0 707	A
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0		ga			d												
Box 68760	Attending Physician: The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physicily the funeral director, page 2 should be detached for use as the bu	Physician/Medical			<u> </u>												
89	certii ending use a	N/UE	IF FEMALE: 23b. Was decedent		23c. If yes, ou			cy death 3	Ectonic	nroanona	M.4				23d. Dat	e of deliv	very
30 30	aw requires that the death cert as been signed by the attendir 2 should be detached for use	icia	in the past 12 ₪ 1 ☐ Yes 2 ☐		4 Pre	gnant at t	time of de		Other (у				Mor	nth	Day Year
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ΚĘ	nysic lis ce direc	2	1 Yes 2] No	Hospital:	Inpatier	nt 2 X El	R/Outpatien	t 3 🗆 I	Othe	er: 4 🗌 Nu	rsing Ho	me 5 🗆 Resi	dence	6 🗆 Othe	r (Specif	(y)
of	ng Pl		27. Manner of Death 1 X Natural	5 Pending	28a. Date (Mor	of injury	Year) 2	8b. Time of injury		28c. Injury work	/ at	1	28d. Describe	how in	ury occurre	d	-
on	eath. or: Af	fica	2 Accident 3 Suicide	Investig	ation	,			М		Yes 2 🗆	No					
井 Division of Vital Records,	or Att fter d irect n by 1	Certificate:	4 Homicide	6 🔲 Could n determin	28e. Place	of Injury	y - At hom (Specify)	e, farm, stre	et, facto	ry, office			28f. Location (City or Tox			r or Rura	al Route Number,
Ö	urs a rral D			V -	-												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	☐ Medical Ex	Physician: To the l caminer: On the ba	sis of exa	amination a	and/or invest	igation, in	n my opinio	n, death of	curred at	the time, date	and pla	ce, and due	to the ca	ause(s) and manner stated.
	thin the	ž	only one) 3 29b. Signature and		Nurse Practioner:	To the be	est of my k	nowledge, d		urred at the c. License		and plac	e, and due to th				
-	F 3 F 8	1	- Signature and	or oortinol	(1)0.21	0/1	(N. LICENSE	161	600		∠90. l	Date signed	, יייוטויטין,	Viet -
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	UPT	1	30. Name and addre	- /	no completed cau	se of dea	ain (item 2	Trans.	rint) DO	1/1.	. 1.	C ex	Rord	1	Acr.	0	Rid 2070.
	St	te.	31. Date filed (Monti		2011 32.5	gistrar'	's Signatur		<u> </u>	100	1000	JEPI	1000	,			10 7 /
	Regist			AFRZJ	4	ener	N/	a. A	are								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03079 State of Maryland / Department of Health and Mental Hygiene Dion Martell Mitchell 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 22, 2011 1944 hrs Medical Examiner Martell Mitchell Dion 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bladensburg Prince George's 5804 Annapolis Road #909 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Wash Jan.30,1983 213-25-4042 1 X M 2 F 28 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ıny 10a State 1 Yes 2 No 28a-f show Bladensburg PG MD with the Maryland Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Annapolis Rd. #909 5804 20710 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married hours after death 2 X No Yes 9 1 Yes 2 X No specify: Specify: Black 4 Divorced If Yes, Give Year 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "u yr other traumatic event, the Medical E marked other than ic event, the Medical Baltimore, MD 21215-0036 Private Plumber Assistant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Campbell B James Mitchell Jane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4101 Parkwood Court Brentwood, MD 20722 Jane Campbell/mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetety 4/29/11 Ft. Brentwood, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Hodges & Edwards F.H. gnature of Funeral Service Lice 3910 Silver Hill Rd., Suitland, MD. 20746 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Intra-oral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by 1 Yes 2 V No 3 Probably 4 Unknown ≦ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical B Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 🗹 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot self Natural FOUND: 1 Yes 2 ✔ No 5 Pending death. Director: 1920 hrs Apr 22, 2011 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 3 V Suicide Could not be or Town, State) 5804 Annapolis Road #909, Bladensburg, MD determined (Specify) Apartment Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State 31. Date filed (Month, Day, Ye istrar

Ling Li, MD

29b. Signature and title of certifier

32. Registrar's Signature

W

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 23, 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ April 17. 0136 РМ Benjamin Mann Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** March 10, 1924 Days ^CVTrginia 1 X M 2 D F Hours 87 **Director** 578-22-8339 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Washington 1 XYes 2 No DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 635 Edgewood Street NE # 102 20017 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 1 Never Married · 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: **Black** 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Manager 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Pleasant Joseph Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20017 635 Edgewood Street NE #102 Washington, DC permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Doris Mann - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) **Glenwood** 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. TWW 20017 Washington, DC 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause preach line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Vear for in the past 12 months? Day 5 Other (specify) Yes 2 No ed by the a 1 Urknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 2 2 No 3 Probably 4 Unknown Records, law requires cate has been signage 2 should b Completed Hollitus II 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? scute 2 🗌 No certificate 1 🗌 Yes • Hospital or Attending Physician: 7 24 hours after death. • Funeral Director: After this certifica eted filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA |은 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined Homicide building, etc. (Specify) City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ည person who completed cause of death (Item 23a) (Type, Print)
12 & 4701 Randolph Rd # 216, ROCKNILL, HD

DHMH 17 Rev 7/2009

Registrar

1144

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

d #29d 5=3=2011 per Pr HCHD, all (per the second)

			1 - State Amend #29d, 5-3-2011, 1	per Dr. Ce	HD al	7	Reg. No. 2	15623
	Physicia		1. Decedent's Name (First, Middle, Last) Constance M. Mace			2. Date of Dea Month April	ath 30 2011	3. Time of Death 5:10 p M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	on of Death	4c. County of Dea	-
مرد	Europal		Morningside Assisted Livi 5. Social Security Number 6. Sex 7. Age	ng (In yrs. last birthday)		ott City ler 24 Hrs. 8. Date of Birl	Howard	thplace (State or Foreign
	Funeral Director		076-46-5673 1 ☐ M 2 🛂 F	59 Yrs.	Months Days Hours		1952	nuntry) NY
]	yland •f show •d at	ctor	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	he Mar or 28a- or putifi	Director	MD Howard 10e. Street and Number	Co.	lumbia 10f. Zip Code		10g. Citizen of What Co	1 🗆 Yes 2 🔀 No
	h with t ns 23a nust be	Funeral	8438 Gold Sunset Way		21045		United	States
ဖွ	ge 1 and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene. At the fleat 23 a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☒ N	No	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		14. Race - Ame Black, Whit	
္ မ	ours al atural" cal Exa	Completed	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates. 15. Decedent's Education		1 Yes 2 X No Specification	ту:		hite
215	iin 72 h ie. han "n: • Medi	dmo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	(Give life. D	kind of work done during mo O NOT use retired)	•	16b. Kind of Business	
d 21	filed with al Hygien d other tl svent, the	Be C	17. Father's Name (First, Middle, Last)	Spec	cial Educator	other's Name (First, Middle,	Educat	ion
/lan	d be fill Mental arked c	힏	Ralph Budynski			Mariam Vick	ivialden dumame)	
<i>></i>	2 should be Ith and Ment 27 is marker traumatic e		19a. Informant's Name/Relationship (Type, Print) Merrily Brome - Personal Re		ng Address (Street and Num W. Benfield			p Code) 21146
ore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	20b. Place of Dispo		Date	20c. Location - City or	Town, State
Baltimore,	it. Page rtment rtant: I njury o	- 6	4 Donation 5 Other (Specify)	Ardent (Crematory	5-6-2011	Hanover,	
Ba	Depar Impo any ir		21. Signature of Funeral Service Licensee When Collins - William		2. Name and Address of Fac	and the same of th		_
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the death. Do not ent	er the mode of dying, such a	as cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Medical		disease or condition Metasta	tic Brain consequence of):	Cancer			- Cristi and Beating
	Examiner	ē	Sequentially list conditions, b.					
To the	d d ansit	Examiner	if any, leading to immediate Cause (Disease or linjury that initiated events Due to (or as a cause (Disease or linjury that initiated events	consequence of):				
760 Cate he executed	cate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a	consequence of):			·	-
	2 20	Medical I	IF FEMALE:					
Box 68	attending p	Physician/N	23b. Was decedent pregnant in the past 12 months?	Petal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
o f	ed de	Physi	g ☐ Unknown					
Records, P.O.	requires that the de been signed by the should be detached	β	Part II. Other significant conditions contributing to death bu	t not resulting in the L	inderlying cause given in Pai		obacco use contribute to Yes 2 🕱No 3 🗆 F	the cause of death?
cord	S & 01	Completed				24a. Was autop	osv prior to	topsy findings available completion of cause of
E Re	sician: The la certificate ha irector, page 2		25. Was case referred to medical		OS Diseas of De	perfo 1 🗆 Yes	rmed? death? 2 ☑ No 1 ☐ Ye	s 2 🗆 No
Vita	nysician: nis certific I director,	To Be	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	Loui-	eath (Check only one) Nursing Home 5 Resid	dence 6 🛭 Other (Spec	Asstd. Lvg.
n of	th. After the funeral	cate:	27. Manner of Death 1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigation	Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2		ow injury occurred	
Division of Vital Records,	r nospita or Attending Priysician: 24 hours after death. Funeral Director: After this certific eted filled in by the funeral director, I	Certificate:	3 Suicide 6 Could not be	y - At home, farm, str (Specify)	eet, factory, office	28f. Location (S City or Tow	street and Number or Ru n, State)	ral Route Number,
	bours a hours a lineral D	Medical (29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death o	occured at the time, date and	nd place, and due to the car	use(s) and manner as sta	ated.
the H	io the nos within 24 h To the Fun completed	Mec	(Check only one) 3 ☐ Certifying Nurse Practioner: To the basis of exponents on the basis of exponents on the basis of exponents of the basis of exponents on the basis of exponents of the basis of the			ate and place, and due to the	e cause(s) and manner as	stated.
ٔ	= ≥ ⊭ ర		by the distribution of the control o		D47447		29d. Date signed (Mont. May 2, 2 March 2, 2	011 1000 2011
12			30. Name and address of person who completed cause of de Dr. Lazris 6336 Cedar Lan	ath (Item 23a) (Type, F	Print) A, MD 21044			
	Stat Registra		31. Date filed (Month Pay Year) 3 2011 32. Begistrar	's Signature	and .			

11-03462 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Mantheiy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Day May 8, 2011 **Medical Examiner** John Paul Mantheiv 1052 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Western Maryland Health System Cumberland Allegany 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country MD Months Days Hours Director 218-96-4872 1 XM 2 F Yrs Apr 23, 1970 41 Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show MD other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Allegany ies I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Corriganville Director 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? 10324 Twin Oak Street 21524 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes 2 X No Specify: white 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 R.E. Michael & Co. <u>salesman</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur or other traumatic event, Be Francis B. Mantheiv (Bland) Mantheiv Barbara A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State MD 21524 Francis Mantheiv PO Box 181 Corriganville father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/11/2011 St. Mary's Cemetery MD 4 Donation 5 Other Specify Cumberland 21, Signature of Funeral Service bicenses 22 Name and Address of Facility Scarpelli Funeral Home, PA Page I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death Immediate Cause (Final disease a Complications of chronic alcohol abuse Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any literaing to immediate cause. Enter Underlying Cause Due to for as a consequence off Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical X UNPENDED \Box AMENDED 23a, 27, per me, g915 6-2-11 sm Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probabiy 4 ✔ Unknown After this certificate has been signifuneral director, page 2 should be c Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) examiner? Hospital: 1 __ Inpatient 2 ✔ ER/Outpatient 3 __ DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Director: Pending 2 __ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City within 24 hours after Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 9, 2011

State 31. Date filed (Month, Day, Year)
Registrar UAV 1 6 9041

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		1 - For State Registrar	Otate of Marylai		rtificate of			Reg. No.	011	15625	
Physic	ian	1. Decedent's Name (First, Middle, Last)	lliam Easto	n Neal	ic		2. Date of Dea Month	Day	Year	3. Time of Death	
/Med Exami		4a. Facility Name (If not institution, give s	treet and number)			Location of Death			unty of Death	1.00	
		The Lions Center f	Rehabilita or Extended (ation Care	Cumber	land		A	lleghen	У	
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 1	h y, Year) 0,1929	9. Birthp Coun WV	place (State or Foreign ntry)	
pur 🖈		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation				1	0d. Inside City Limits	
faryla sho	5	WV Hampshi		Romne						Y∐Yes 2 □ No	
the N	Director	10e. Street and Number		- TOMITO	10f. Zip Code			10a. Citizer	of What Coun	itry?	
3a or	Ö	72 Larson Place			26	757		9	US		
death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S)	pecify Yes or No-	- 14.	Race - Americ		
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	þ	1 Never Married 2XXMarried 3 Widowed 4 Divorced	1X Yes 2 No 195 If Yes, Give Year or Dates: 1954	52- .	il Tes, specily Cuba il □Yes 2X No	Specify:	o nican, etc.)		Black, White, e ecify: Wh	ite	
2 ho	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	ation	king	16b. Kind	of Business/Inc	dustry	
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done DO NOT use retired		arig				
led will her the her the		8		Sec	urity Gua		. /Final Adiabatic		choo1		
ntal Hed oth	Be	17. Father's Name (First, Middle, Last) William Garland N	onlia			18. Mother's Nam	•		rname)		
hould id Me mark matic	၉	19a. Informant's Name/Relationship (Ty)		10h Mailin	ng Address (Street		le Simme		awa State 7in	Code)	
and 2 s ealth ar m 27 ls ner trau		Betty Nealis	se. Fility		Larson Pl					Code)	
t Hea t Hea trem tem		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date Date		ion - City or To	wn, State	
Pages ent o ht: If I		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		cemetery or other place.	i = /10	/2011	Romr	iev		
permit. Pages 1 and 2.9 Department of Health at Important: If Item 27 Is any Injury or other trainonce.		21. Signature of Funeral Service License	-		2. Name and Addre	1			,	Inc.	
P P P P P		Sand Man	0	2.	30 E. Mai	in St., R	omney, V	WV 267	757		
Physician / /Medical Examiner		23a. Part 1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	which	candi					Approximate Interval Between Onset and Death	
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
ding Physician: The law requires that the death certifich. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		230	d. Date of deliver	ery Day Year	
equires that een signed b	b	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.				he cause of death?	
requ been should	Completed										
ne lav has ge 2	l dr						24a. Was autor perfo		prior to co death?	opsy findings available empletion of cause of	
n: Th fficate or, pa	ပ္မိ	25. Was case referred to medical					1 □ Yes	2 No	1 ☐ Yes	2 X No	
sicia s cert	00	examiner?	ospital: 1 ☐ Inpatient 2 ☐	7 EB/Outpotion	oth	er: Nursing II			7.Other (0	£.)	
g Phy er this	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	f 28c. Inju	y at	ome 5 Resi			<u>y)</u>	
Attending r death. ector: After by the funer	aţio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	M 1 □	k? Yes 2 □No					
or Attence after death Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (S City or Tow							(Street and Number or Rural Route Number, wn, State)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) ar date and pl	nd manner as s ace, and due to	stated. o the cause(s)	
To the within To the somple	Me	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)	
		1. Com	12		DO	03676	2(0	ma	982	2011	
,		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type,					~		
		W. L. camadita	1) imr	000	1 antin	Da 12 /	71-0	100	JW W	1 21502	

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, MAY 1 6 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		P	lease 7					k. Ensure A Health and I	•	•	ble.	
-	_	State Registrar				Cer	tificate of l	Death		Reg. No. 2		15626
Physicia Medic		1. Decedent's Name (First, M. Lawrence A.	iddle, Last) Orai						2. Date of Dea Month	Day 23-2	Year	3. Time of Death
Examin	er	4a. Facility Name (if not institu						or Location of Death	1	4c. County of		
Euroral		Anne Arundel 5. Social Security Number	6. Sex		7. Age (In yrs.	last hirthday)	Annapol If Under 1 Year		8. Date of Birt	Anne		deL place (State or Foreign
Funeral Director		213-64-0284 Usual Residence of Decedent	1 🛚	М2□F	53	Yrs.	Months Days	Hours Min.	June 1		Mary	land
aryland a-f show fied at	ector	10a. State 10b. Cou	unty	unde1		ity, Town or Lo Edgewat					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
ith the M 3a or 28 it be noti	Funeral Director	10e. Street and Number					10f. Zip Code			10g. Citizen of W		
ems 2	nue	1032 Turkey 11. Marital Status		12. Was Dece	dent Ever in U	.S. 13. V	2103 Was Decedent of H	3 / Hispanic Origin? (Sp	pecify Yes or No-	USA 14 Bace		an Indian,
s after de al", or ite Examine	ed by F	1 Never Married 2 3 Widowed 4 V Divo	Married	Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 ሺ No e			an, Mexican, Puerto	D. white Division start			etc. ite
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by		edent's Edu nighest grad	cation		(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wor	king	16b. Kind of Bus	siness Ind	Justry
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ntal Hied oth	To Be	17. Father's Name (First, Midd Francis		h Orar	100					Maiden Surname) e Hopkin		
ould bud Me		19a. Informant's Name/Relati			ige	10h Mailir	na Addraes (Street	and Number or Ru				Codel
and 2 sh Health an em 27 is ther trau		Nicole M. Bur				60 Ha	ampshire	Street,	Romney,	WV 26757		
Page 1 nent of I ant: If its		1 Burial 2 Crema 4 Donation 5 Oth			State		sition (Name of natory or other place ematory	_{ce)} 05/0	Date 03/2011	Edgewate	•	own, State Maryland
permit. Departr Imports any inju		21. Signature of Funeral Serv	ice Lice se	A d	1			ess of Facility Geo	_			
		23a. Part 1. Enter the disease	/ W	ney	auand the dea			ons Islan	 		er, I	
Physician/ Medical		shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	e, or compli- list only one	cause on ea	ch line.	Stag	er the mode of dyli	o P	or respiratory arr	est,		Approximate Interval Between Onset and Death
Examiner				Due to	or as a consec	, 13	nias					
uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events C. Due to (or as a consequence of): Cause (Disease or iinjury that initiated events C. Due to (or as a consequence of):										
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	1 Live	nant at time of	tal death 3	Ectopic pregnan Other (s <i>pecify)</i>	су		23d. Date Mon		ery Day Year
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sician: The law is certificate has the irector, page 2 s		25. Was case referred to med	ical				00.5	10 11 61	1 🗆 Yes	rmed2 de	eath?	2 No
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e Hospita 124 hours e Funeral leted fille	Medical	(Check 2 <u></u> Media	cal Examin	er: On the bas	is of examination	on and/or inves	tigation, in my opini	e, date and place, a ion, death occurred ne time, date and pla	at the time, date a	nd place, and due	to the car	use(s) and manner stated
To th withir To th comp	2	29b. Signature and title of cer	tifier	MI)	70 110 5001 0.11	ny iviewie u ge,	29c. Licens			29d. Date signed		
الملح		30. Name and address of per	son who co	mpleted caus	se of death (Ite	S : .	Print) 200	7 Tid	enale	or Col	-17	Dave 21401
Stat		31. Date filed (Month, Day, Ye	ar)	32.	egistrar's Signa	ature 1	it 1-	A Ann	م احرا	- 1/411)	1.	-1701
Registra	ir	APR 2	0 201		nun	p. 19	aver					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month 2011 Walter Theodore Osterloh May 3:21 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Days Hours Min 7416-1924 86 Yrs MD 214 20 9125 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be i Funeral United States 8260C Stone Crop Drive 21043 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Kitchen Cabinet Comp. Cabinet Maker other traumatic event, Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Walter Osterloh Louisa Goodrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Steven Osterloh/Son 3446 Orange Grove Ct. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Ardent Cremation Svc. 5-2-2011 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Them 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 Yes 2 No 20 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Norther (Specify) Hespic within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature and 29d. Date signed (Month, Day, Year) MD 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 ARATHI 701 BALTIMORE MD 21214 KUMAR SUITE 4105 31. Date filed (Month distra State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #195are of Maryland / Department of Health and Mental Hygiene

		-	For State Of IVIAI		tificate of D		, ,	eg. No.2 N 1 1	15628
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deat Month		3. Time of Death
	Medic	al	Carol Josephine Oberdalho 4a. Facility Name (if not institution, give street and number)	ff	41 O't T	· · · · · · · · · · · · · · · · · · ·	May	2 2011	5:00 A ^M
	Examin	er	306 Linton Run Road		4b. City, Town, or L Port De			4c. County of Dea	th
	Funeral	1		In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	9. Bi	thplace (State or Foreign
	Director		218-40-2305 1 M 2 A F Usual Residence of Decedent	67 Yrs.	Months Days	Hours Will.	07-25-1	943 Vi	rginia_
	and show i at	P		10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryli 28a-f otifiec	irect	Maryland Cecil	Port Depo	osit				1 ☐ Yes 2X No
	th the	al D	10e. Street and Number 306 Linton Run Road		10f. Zip Code 21904		1	10g. Citizen of What C United St a	
	ath wi	Funeral Director	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. W	Vas Decedent of His	panic Origin? (Spe		14. Race - Am	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.	lf .	Yes, specify Cuban	, Mexican, Puerto F	Rican, etc.)	Black, Whi	
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d 2	led wi Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)	1000	T	18. Mother's Name			10015
/lan	should be file and Mental I 7 is marked or raumatic eve	욘	Andrew Mason Dunn			Martha	West		
Maryland	shoul		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Z	
e) O	and 2 Health em 27		Edward Oberdalhoff/husband 20a. Method of Disposition	306 20b. Place of Dispos				eposit, MD	
Baltimore,	age 1 ent of nt: If it	,	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem R.T. Foar	natory or other place	Hams-03	2011	•	n, Maryland
a E	permit. F Departm Importar any injur		21. Signature of Juneral Service Licensee	22	. Name and Address	of Facility $\mathbf{R} \cdot \mathbf{T}$	Foard	Funeral Ho	
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المسيا	Physician/ Medical Examiner	ıer	Sequentially list conditions,	1.00	truch	////		-	Approximate Interval Between Onset and Death
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on o	ending ath. ir. Afte	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	Work? M 1 □ Y	∕es 2 □ No			
Division of Vital Records,	al or Atta s after de l Directo d in by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
_	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exa	mination and/or invest	tigation, in my opinior	n, death occurred at	the time, date an	nd place, and due to the	cause(s) and manner stated.
	To th within To th comp		29b. Signature and title of certifier	1007	29c. License			29d. Date signed Mon	
D	1		·	YVI	150	06080	XT	00/2	12011
	5		30. Name and address of person who completed cause of dea	500 ly	oper Che	saplai	lu Dr.	Bela	Y MDZIUY
	Sta Registra		31. Date filed (Month, Day, Yellr) V 32. Register	s signature	parked	*			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 A^{M} Pipkin April 26. 9:35 Joan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 877 Clubhouse Village View Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🖈 F Days Months Maryland Director 220-36-1341 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21401 877 Clubhouse Village View 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Healthcare** Medical Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Salvadore Helen Kasin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 877 Clubhouse Village View, Annapolis, MD 21401 Frank Pipkin - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 5/3/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Musel 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ UMa disease or condition 1 MOS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 🗌 Yes 2 🗎 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a, Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29d. Date signed (Month, Day, Year)

State Registrar STAVT E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

selonich, mo

2011

Annapolis, Md.

PKWain

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ NORA DELORES SHAW PROCTOR 1004-25-2011 Year 2:02 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death rince George's Clinton Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Country) NC **Funeral** Months Days Hours Min. 0 5 Month (Pay, 1 Year) 2 0 072-22-0154 90 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Prince George's Upper Marlboro MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10808 Devlin Drive 20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be f Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev ပ Blanche Faulcon L. M. Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10808 Devlin Dr., Upper Marlboro, MD 20772 Loretta D. Proctor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairview Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 KRemoval from State Westfield, NJ 05-03-201 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, Tisha MO1616 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. nterval Between nset and Death Athroderst. u Landovasola D13218 Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to libras a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year the g Unknown g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by has been sig je 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director, / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#7. PerFHPCC5-2-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Elbridge Price 23:48PM 4 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sprin Woodside Silver 1 onto men If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe Age (In yrs. last birthday, te of Birth 9. Birthplace (State of Foreign **Funeral** 1 1 M 2 D F Months Hours Min 1-29 Day 823 Geismar _87 88 Director 434-28-9905 . A Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tiffer 323 or 28a-f show ant if ifem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ₹ Yes 2 □ No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8402 Greenwood Ave. Apt. 20912 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Black δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Price Beatrice Nicholas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara P. Davis/Sister 518 Nicholson Street NW Washington DC 20011 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5-4-2011 Cheltenham, Maryland Cheltenham Cemetery nature of uneral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th Street NE Wash. DC 20017 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or iinjury Examine Due to (or as To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and compileted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No Dav Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Usertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number H67624 completed cause of death (Item 23a) (Type, Print)

Registrar

State

and address of person who

20910

Silver

32. Regis

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its "Modical Examinar man be notified at Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Reg

ı	State Registrar 1. Decedent's Name	e (Firet Middle	l ast)		Cei	artment of F	Death	, ,	eg. No 20	3. Time of Death
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			, give street and numb	ber)	-	4b. City, Town, or		th	4c. County	
4	5. Social Security N			. Age (In yrs. la	st birthday)	EASTON If Under 1 Year	If Under 24 Hr		TAL	9. Birthplace (State or Foreign
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	10a. State	10b. County	, ANDRELO		Town or Lo					10d. Inside City Limits 1 □Yes 2 ▼No
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	19a. Informant's Na		INS/ WIFE						NSTOWN,	MD 21658
	20a. Method of Dis 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation	3 ☐ Removal from St	tate CHE CEN	metery, crei	osition (Name of matory or other place KE CREMAT	CON AP	RIL 30,		City or Town, State SVILLE, MD
	21. Signature of Fu	uneral Service	Licensee	, CLIN	72 FE	2. Name and Addre	ess of Facility	L-L	FUNERA	L HOME, P.A.
-	chack or has	ne disease, or	complications that car	used the death.				ac or respiratory arr		Approximate
	shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list conduction of the cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nditions,	a. Due to (o	used the death. ch line.	ence of):		ng, such as cardi	ac or respiratory arr		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day ам Pauline Ridgeway 9:00 04 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Fort Washington Nursing & Rehab Ft. Washington Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🏝 F Days 11/06/1920 Months Hours Min. Director Yrs. 579-32-3119 90 South Carolina Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 □ No Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2706 Keith Street 20748 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Midowed 4 Divorced Specify: Year or Dates **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service <u>Cafeteria</u> Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Larkin Andrews Ada Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Amer Court Ft. Washington, MD 20744 Dana Ridgeway/Son injury or other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or of 🛚 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 04/25/2011 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Jourge Mongoney CheatGan 3401 Bladensburg Road Brentwood, MD 20722 Part 1. Inter the disease, or color lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Arteriosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Non Healing Skin Wound 1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? injury Natural 5 Pending Division 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

12070 Old Line Center

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

hillip Wisotsky,

31. Date filed (Month, Day, Year)

D18545

Waldorf, MD

April 23, 2011

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGIA JUANITA REED APRIL 2011 3:35 P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2225 WILLIAMS DRIVE HAVRE DE GRACE HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F DEC 28 1925 212-22-7199 Director 85 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 Tes 2 No HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2225 WILLIAMS DRIVE 21078 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Merical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT US GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MENZO EVANS ELSIE V. REED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE O. REED / SISTER 901 BARNETT LANE, APT 417, ABERDEEN, MARYLAND 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 05/03/11 GLEN BURNIE, MD 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREFT, HAVRE 21. Signature of Funeral Service Licensee MD_21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician CARDIAC ARREST disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 1 ☐ Yes ∠ □ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifia 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

ONDOK

32. Registrar's Signature

			Please	State of M				c. Ensure A lealth and M	-		_	
		-	For State Registrar	State of W	ai yiai iu /		tificate of E			Reg. No	1100	15635
			Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ith		3. Time of Death
	Physicia Medic				JZICKA				APRIL	2 .	7 2011	12:34 M
4	Examin		4a. Facility Name (if not institution, give				4b. City, Town, or BERLIN	Location of Death		40	County of Dea	
	Funeral Director		5. Social Security Number 6. S 219-40-7678	бех К м 2 🗆 F	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Month, Day JULY 28	h (, Year)	9. Bir Cc MAI	thplace (State or Foreign juntry) RYLAND
	d d		Usual Residence of Decedent 10a. State 10b. County		10c, City, Tov	un or Loc	ation					10d. Inside City Limits
	Marylan 28a-f sh xtified a	recto	DELAWARE SUSS	SEX	1	BYVI						1 ☐ Yes 2 🎇 No
	ith the I 23a or 2 st be no	Funeral Director	10e. Street and Number 37117 WHITETAIL	DDIVE			10f. Zip Code 19975			_	itizen of What Co	ountry?
	eath v	Fune	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W		spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	T	14. Race - Ame	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2 Amarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 K If Yes, Give Year or Dates.	No		Yes, specify Cuba		Rican, etc.)		Black, Whit	
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212	within giene. er thau		Elementary/Seconday (0-12)	College (1-4 or t	5+)		ICIAN				MUSIC	
pu	tal Hyg d othe	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	, , ,		Surname)	
r <u>y</u>	uld be d Men marke matic		FRANKLIN W. 19a. Informant's Name/Relationship (RUZICKA				ROSE	KNIZER			
⊠a	12 sho alth an 27 is ir traul		RICHARD T. RUZICK		1		-	and Number or Rura				
ore,	of Her of Her of rothe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □		20b. Place	of Dispos	sition (Name of atory or other plac		Date		ocation - City or	
ţ	t. Page tment rtant: I		4 Donation 5 Other (Spec	ify)		TORY	OF DELM	ARVA 4/2	8/11	DEL	MAR, DEI	LAWARE
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Licen	99) // X	0134	- 1	Name and Addres	ss of Facility FUNERAL H	OME. SE	LBY	VILLE, I	DE 19975
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that cause							,,	Approximate Interval Between
	Physician	ïi	Immediate Cause (Final disease or condition	MULT	OVG	an	Kail	110				Onset and Death
1	Medical Examiner		resulting in death)	ne to (or as	a conse	of):	to.	Bleed	1			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):	100:51	DILLO				
134	be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):						
7.09	be e	ca	L	d								
70D: 6876(ertificar ding pł	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							
175 Box	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal dea		Ectopic pregnand Other (specify)	cy			23d. Date of de Month	Day Year
P.0	that th ned by e detac	y Ph	Pa Dther significant conditions	contributing to death.	out not resulting	g in the u	nderlying cause giv	in Part I.	23e, Did to	bacco	use contribute to	o the cause of death?
ds,	equires sen sig ould b	Completed by	Chloure Or	טיושאונכל	7 IN	11 /10	AND A	your.	1 🗆 `	Yes 2	!□No 3□F	Probably 4 Unknown
	has be	mple					/ -		24a, Was autop	SV	prior to	utopsy findings available completion of cause of
<u> </u>	in: The tificate or, pag	Be Co	25. Was case referred to medical	1			26 Pl	ace of Death (Checi	1 Yes	2	lo 1 ☐ Ye	s 2 🗆 No
Vital /	nystcia nis ceri direct	To B	examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 ER/0	Outpatien	Othe	er.		dence	6 ☐ Other (Spe	cify)
of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Da	ıry 28b ıy, Year)	. Time of injury	28c. Injury work	/ at ? Yes 2 □ No	28d. Describe h	ow inju	ry occurred	
۲۹, A Division	Attender deat ector:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not lead to determined	be 28e. Place of Inj		farm, stre	M 1 L	res 2 🗆 No				ural Route Number,
	spital or rours afti reral Dir filled in			building, et		death o	coured at the time	date and place or	City or Tow			ated
Ruzia	the Hos hin 24 h the Fun npleted	Medical	only one) 3 Certifying Nu	niner: On the basis of e rse Practioner: To the	examination and	l/or invest	gation, in my opinic eath occurred at the	on, death occurred a e time, date and plac	t the time, date a	ind plac	e, and due to the	cause(s) and manner stated.
2	P		29b. Signature and title of certifier				29c. License	number 1585		29d.,Da	ate signed Moni	th, Day, Year)
	6nm		30. Name and address of person who	completed cause of	death (Item 23a) (T/pe, p	rint) Mala	1 Price	0 10	, li	n Mi	7/8/1
	Stat		31. Date filed (Month, Pay, Yar) 2	32 Registr	ar's Signatur	bo	www.	1 1/10	1,50	rill	<u> </u>	10111

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 21 per DVR G915 5/16/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 201109:50 A M William Reginald Redman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western MD Regional Medical Center **Allegany** Cumberland 7. Age (In yrs. last birthday) 86 yrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 1925 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Paw Paw, **Director** 233-34-3791 Usual Residence of Decedent or 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1. ☐ Yes 2 ☐ No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 135 Chestnut Street traumatic event, the Medical Examiner must 26726 USA than "natural", or items Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status ned Force Black, White, etc þ 1 Never Married 2X Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: **Black** If Yes, Give 3 Widowed 4 Divorced Completed WW II Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Loading Dept. Truck Driver Paper Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Smith Milton Redman permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 135 Chestnut Street, Keyser WV 26726 Rita E. Redman/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4/9/2011 4 Donation 5 Other (Specify) Potomac Mem. Gardens Keyser, WV Smith Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brian L. Smith per DVR 85 S Main Street, Keyser WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph. sician/ Myocardial Infarction disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has b page 2 s autopsy performed? Yes 2 K No death?
1 Yes certificate Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after death To the Funeral Director: / completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1톴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tij 29c. License number 29d. Date signed (Month, Day, Year) 5,1,11 D0068455 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Ardalan Enkeshafi, MD

32. Registrar's Signature

P O Box 539 Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harry Elwood Stephens, Jr. April 29, Day 2011 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🙀 M 2 🗆 F Days Months March 23. 218-24-4832 Director 83 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Phillips Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed Specify: white 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator produce stand Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental item 27 is marked Harry Elwood Stephens Albina Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy S. Meekins daughter 407 Edlon Park, Cambridge, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 5/2/11 East New Market, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and shock in the cause of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠No 24a. Was an autopsy performe å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifie ess of person the completed cause of death (Item 23a) (Type, Print) 30. Name and add 2015 A 31. Date filed (Month, Day, Year, State MAY 03 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:15 p M Lucile STOKES April 20 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Loyalton of Hagerstown Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours 12/9/1924 Pennsylvania Yrs **Director** 213-20-5421 86 Usual Residence of Decedent 28a-f show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified Maryland Anne Arundel Annapolis 1 Tes 2 X No 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 21403 USA 1138 Bay Ridge Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. ŏ δ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Tes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill timent of Health and Mental tant: If item 27 is marked or 2 Nadine Taylor Raymond Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Fern Augusti - Daughter 10741 Green Valley Rd, Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Hillcrest Mem Garden's 4/28/2011 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home - West 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNOUMON Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** RNDOME Sequentially list conditions, District for the supplier of the constraints of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No been signed by the atte Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy death? after death.

Director: After this certificate! Yes or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မှ 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours at To the Funeral D Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26ay KEITH SPRAGGIN APKTL 20 T 3:45 a M Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** 4c. County of Death Fort Washington Prince Georges Ft. Washington Nursing and Rehab Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 X M 2 Days Hours Min 03/15/1963 Director 578-96-4669 48 Virginia Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Forestville Prince George's 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1726 Forest Park Drive 20747 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2X No Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the t. Page 1 and 2 should be filed with thrent of Health and Mental Hygier rtant: If item 27 is marked other t njury or other traumatic event, th vears Chef Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Spraggin Francine Via 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Spraggin/Mother 1726 Forest Park Drive Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 05/02/2011 Alexandria, VA 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License na 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physiciana disease or condition resulting in death) a Human Immunodeficiency Virus Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autonsy death? certificate 2 K No 1 Yes 2 X No Yes the Hospital or Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident
Suicide the Funeral Director: npleted filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

only one) 29b. Signa

Laxmi N. Berwa 7700 Old Branch Ave., Suite C-101 Clinton, MD 20735 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2011

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D24535

29d. Date signed (Month, Day, Year)

04/28/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APR'IL 22 201 I ear 9:10 A SPALDING RADOLPH Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HYATTSVILLE ST. THOMAS MORE NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F (Month, Day, Year, PRTL 9 1 PANAMA **Director** 67 096-48-6102 PRIL 1944 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S BLADENSBURG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>5217 NEWTON STREET #101</u> 20710 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

TY Yes 2 NARMY

If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH PRIVATE SECURITY OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AUGUSTINA NILES ပ GEORGE S. SPALDING permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZERINA SPALDING/DGT 4103 BEALL STREET HYATTSVILLE, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY 5/2/11 CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dis shock, or heart fau Immediate Cause (Final disease or condition resulting in death) se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death . List only one cause on each line In Farction Physician/ Lebral 2 Medical Due to (or as a consequence of) Examiner nteriosclenote CANDIOSASCUlan Disease Sequentially list conditions. Examine if any, leading to initialize cause. In the Unique of Cause (Disease or linjury Dubito (or as a consequence of; been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISUNDON Diabetes wellitos 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? failure Ventilupon Dependent 24a. Was an autopsy Encephalopathy ahoxic 1 Yes 2x No Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be (26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should

Baltimore, Maryland 21215-0036

Medical 3 State

31. Date filed (Month, Day, Year) APR 2 9 2011 Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

4203 Docenshory Rel Hyatpulle MD 20781 ORE MID 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

City or Town, State)

29d. Date signed (Month, Day, Year)

1- For Find #5, 5-3-2011, per FHDR, HCHD in all of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day April 2011 Year **Physician** 27 7:00 AM Thomas J. Sundberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia Lorien Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–14–1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 091-16-6353 **Funeral** Days Hours Min 1**⊠** M 2□ F Yrs NY 89 091 66 6353 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location show items 23a or 28a-f shorer rust be notified at 1 ☐ Yes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21044 United States 6336 Cedar Lane #239 filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married 1 ☐Yes 2X No Specify: White If Yes, Give Year or Dates: 1941-45 Specify Completed by 3 Widowed 4 Divorced natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security College (1-4or 5+) Elementary/Secondary (0-12) Administration Farm Claims Examiner marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ant: If Item 27 is marked o Phillip Sundberg Teresa unknown ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4958 Valley View Overlook Ellicott City, MD 21042 Joseph J. Sundberg/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-28-2011 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 llus 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atrial Fibrillation **Physician** /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □Yes 2 □No neral Director; / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P (M) April 27, 2011 D47447 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 54 Andy Lazris MD 6334 Cedar Lane Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 28 2011 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

5641

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ Day 201 1 Year Donald Wayne Smith, Sr. 8 0300 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Elkton Cáre and Rehabilitation Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 \square F Days Hours 204-18-3877 Pennsylvania 87 1924 Director Jan. Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 257 Fletchwood Road 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1943–46 Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White 3 V Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working National Vulcanized al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Fiber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked ot မ Martha Gradwell Joseph C. Smith other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau S. Chestnut Drive, Elkton, MD 21921 Claire Vulcan/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place All Saints Cemetery | May 11, 2011 Wilmington, DE 22. Name and Address of Facility Hicks Home for Funerals, P.A. Sign ture of Funeral Service Licensee 1 103 W. Stockton St., Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death evere Casdionino Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Stie to (or as a consequence of) Exami and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death
Unknown Yes 2 No signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 2 🗌 No 1 🗀 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No hours after death. within 24 hours after death

To the Funeral Director: A
completed filled in by the f ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie MD D0062190

Registrar
DHMH 17 Rev 7/2009

State

SVITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN MD

32. Registrar's Signature

HERMAN ITMY

AUGUSTINE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Laura Virginia 2. Date of Death 3. Time of Death Thomas Physician/ April 30° 2011 ar 1:35 P Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death
Dorchester Examiner 4b. City, Cambridge Mallard Bay Care Center Social Security Number 8. Date of Birth June 10 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** ^{Year} 19<u>14</u> Days Maryland Hours 1 □ M 2 🗗 F Months Director 216-40-3431 96 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Examiner must be notified at Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 520 Glenburn Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 white 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Wilson Florence Orem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important: If item 27 is Carolyn T. Parks daughter 101 Wisteria Drive, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Ь 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cen 5/5/11 injury o 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur di Funeral Service Licensee any 700 Locust St., Cambridge, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Do mentic Immediate Cause (Final Onset and Death Physician/ Advonce disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. r. ind. r.ying Examiner Due to (or as a consequence of) anding physician and use as the burial-transit Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death , the & signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 2 4 NO 1 Tes Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🗖 No Other: Certificate: To 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral completed filled in the funeral completed filled filled in the funeral completed filled fille atural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD 21613 NOMAN THANWY 503 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G915 5/17/11 dk
State of Maryland / Department of Health and Mental Hygiene State Registral Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 25, Day 2011 Bull Anne Turner 4:00 a™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 422 Druid Hill Ave. Salisbury . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕇 F Days 222-09-5912 91 Months Hours Min 05/01/1919 Director Yrs Virginia Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 422 Druid Hill Ave. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married δ Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph S. Bull Julia Hyslop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Turner/son 23594 Keen Rd, Chance, MD 21821 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Franktown Cemetery 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/28/2011 Franktown, VA 4 Donation 5 Other (Specify) 21. Si nature of Funeral Service Licensee any in Holloway Funeral Home Professional Association Hompson Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -orohary Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year Day Pregnant at time of death 5 Other (specify) should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 70 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work s after death. 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical EXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minimal as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the firm, acts and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

SIE

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Frey, M.D.

31. Date filed (Month

U00 53394

1205 Pemberton Dr., Suite 105, Salisbury, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2011 THOMPSON 1:45 VERL THOMASINA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 9. Birthplace (State or Foreign Country) VIRGINIA Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days JUNE 21, Year 1959 **Director** 577-88-4319 51 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND PRINCE GEORGE'S LARGO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 10704 MT. LUBENTIA WAY 20774 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL WORKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thrent of Health and Mental rant; If item 27 is marked ည THOMAS BROOKS MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMYA C. THOMPSON/ DAUGHTER LUBENTIA WAY, LARGO, 10704 MT. MD 20774 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) SPOTSYLVANIA, VA SYLVANNAH CHURCH CEM. 05/03/2011 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD, HYATTSVILLE, MD 20785 23a. Part 1. Chiler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart gillure. List only one cause on each line.

Immediate Cause (Final disease or condition a Lung Cancer Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Examiner e endocorditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s certificate has performed 1 ☐ Yes 2 ☐ No 2. completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No မ 1- Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1- Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1- 🖃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print)

TANNA LACHTCHININA

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ 2 0°1 1 Sharon Marie Thomas 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15815 Knight Bridge Court Prince George's Accokeek 9. Birthplace (State or Foreign Country) DC Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 3-28-1-947 Hours 1 □ M 2 🛛 F 64 Director 579 62 4252 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nother 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15815 Knight Bridge Court 20607 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Specify: Black 1 Yes 2 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Care Provider Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Bazemore Audrey Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15815 Knight&ridge Ct.Accokeek MD 20607 Larry Thomas/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Resurrection Cem. 5/9/2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Lig 2294 Old Washington Rd.Waldorf, MD20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PROGRESSIVE BREAST months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant. 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months 1 Yes 2 No Pregnant at time of death been signed by the should be detached a 🗌 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has I autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 11/10 **Director:** After this certific I in by the funeral director, 25. Was case referred to ____ical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: Natural
Accident 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1135 Woodyard Rd Ste#101

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 25 per me, g915,05/19/2011dhb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marquerite Mae Tibbitt Month Year 10:18 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 icomico REGIONI Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Days Hours Min. 02/16/1922 154-18-6603 89 Director Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 301 Amherst Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marguerite Mae Young Edward Emerson Cooley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 Riley Run Rd., Forest, VA 24551 19a. Informant's Name/Relationship (Type, Print) Barbara Frear/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/29/2011 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 251 Medical resulting in death) Due to (or ... a consequence of): Examiner Spiration CERTIFICATION APPROVED BY MEDICINE EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No igned by the atte Pregnant at time of death 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia After this certificate has autopsy 25. Was calleferred to medical 1 ☐ Yes 2 ☐ No Yes 2 ... within 24 hours after death.

to the Funeral Director: After this certifical ompleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours a

State Registrar DHMH 17 Rev 7/2009 27. Manner of Death

1 Natural

29a. Certifier

(Check

30. Name and ad

only one)

Accident Suicide

Homicide

5 Pending

6

nature and title of certifier

Investigation

Could not be

determined

IEMEY

Certificate:

Medical

100

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Carroll S

29c. License number

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year,

28a. Date of injury (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print) OR

mi

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month C4 Fannie Sue Thomas 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 M 2 X F Months Hours Oklahoma Director 217-42-6091 84 Usual Residence of Decedent 10a, State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1721 Riverside Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirans injury or other traumatic event, the Medical Examirans in the Medical Examira ģ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white Completed 3 Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Rose McClure Fred Grant Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26416 Nanticoke Rd., Salisbury MD 21801 Fred Thomas/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/29/2011 Shad Point Cemetery Salisbury, MD 4 Donation 5 Other (Specify) Funeral Service HOTTOWAY TUTETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that cab, ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one caus Interval Between Onset and Death Into ediate Cause (Final Enysician/ CARCINOUA ANCREA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjulated that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2/☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has After this certificate 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funerol C. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗆 No 6 Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 2005 2410 om 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 O 1307 WAY 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30, 2011 Physician/ Alice Bohn Veazie 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 24, 1925 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours New Jersey Director 066-14-3874 85 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Dorchester Cambridge or items 23a or 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 411 Glenburn Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: "natural", Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be Frederick Bohn Hazel Learned 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 5885 Travers Wharf Road, Cambridge, MD C. Richard Drescher III son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗌 Burial 2 🕱 Cremation 3 🗆 Removal from State 5/3/11 Delmar, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part // Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pitysician disease or condition Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, Due to or as a consequence of if any leading immediacause. Enter Underlying Cause (Disease or iinjury that initiated events /sician and Exami Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XX

9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law this certificate has autopsy perform 2 No. 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 710 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident Certificate: 28b. Time of 28c. Injury at work?
1 🗀 Yes 2 🗆 No 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending М Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 63 a leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com AR -ois 100 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Medical Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson, D.O. 100 Bramble St., Cambridge, MD 21613 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 08 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter M. Wright :10 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES PLATA MEDICAL CENTER 5. Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** ^{Year)} 1918 1 🛛 M 2 🗆 F 92 Months Days Hours Min June 26 212-14-5686 Mary land Yrs Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1375 Marshall Hall Road 20616 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced WWII the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 21 Heavy Equipment Operator Self Employed permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Lodge M. Wright Elizabeth L. Thompson Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David H. Wright Son 1375 Marshall Hall Road, Bryans Road, Md. 20616 Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 4 20c. Location - City or Town, State 2011 XBurial 2 Cremation 3 Removal from State Bryans Road, Maryland Shiloh United Methodist Church 4 Donation 5 Other (Specify) 21. Signature of Funeral S Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ MELEMOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Dav should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 performed? Yes 2 No 1 Yes 2 No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: Certificate: To 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 \square Yes 2 \square No 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 X Natural 5 Pending injury Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and tine 29c. License number 301 0061 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp assett MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Fryure All Copies Are Legible.
Amend Item 30 per DVR G915 5 Fryure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 3. Time of Death 2011 ear 25 0915а м Stanley Sylvester Williams 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1710 Dale Lane Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **X** M 2□F Months Days 45 Yrs 7-18-1965 PA 194-54-2358 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1710 Dale Lane USA 21801 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: speniack 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Detailing Soft Touch Car Wash 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, John Lewis Elzey Brenda Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Williams/Mother 1710 Dale Lane, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4-30-2011 Hebron, MD Springhill Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eachlity 917 W. Isabella St. Bennie Smith 21. Signature of Funeral Service Licens Funeral Home Salisbury, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ A 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 340 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24Z2N0 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) € PYes 2 No 34 COULDatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Natural Injury 1 Tes 2 No investigation Ź ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Contifying Physician: To the best of my knowledge death oncomed at the time, date and place, and due to the dates(s) and manner as stated.

[Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner the death certificate be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68760, as the attending | signed by the a s certificate hes b lirector, page 2 s Hospital or Attending Physician: director

Physician

/Medical

Examiner

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Pages 1 end 2 should be

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with the Maryland

filed within 72 hours after deeth

Baltimore, Maryland 21215-0036

in Nowperson 10 Abours effect death.
the Funeral Director: Affect his c completely within 2 To the I To the

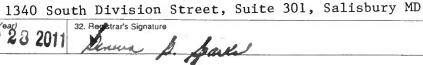
State

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b Signature and title of certifier

Kazi Khan,



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vileetus Emory Wells Manth 955 M Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 51456414 MICHMICO TENINSULA Social Security Numbe 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign MD Country) Months Days Hours Min 2-18-1925 Director 220-26-3857 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No Wicomico MD Delmar 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8965 Stage Road 21875 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? 0 1 X Never Married 2 Married Black, White, etc. Completed by Maryland 21215-0036 'natural", If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced speWhite Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked o ည Benny T. Wells Helen Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f and 2 s f Health item 27 Florence Richardson/Sister 8925 Stage Road, Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) LC 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Other (Specify) Direct Cremation, 4-29-2011 Dover, DE Behnie and Address of Excility 917 W. Isabella St. Signature of Juneral Service Licensee Funeral Home Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Community disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Year 1 Yes 2 9 Unknown ed by the a detached f P.O. | s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy e Hospital or Attending Physician: The l 24 hours after death. e Funeral Director: After this certificate heleted filled in by the funeral director, page death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes ☐ Accident Investigation 2 🗌 No Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) πpleted filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 only one) 3 Certifying Nurse Practioner: To the be st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date sighed (Month, Day, Year) D59931 30. Name and address Mo completed cause of death (Item 23a) (Type, Print) Brett Hotma 100 E. Carrell St. SAlisbury md, 21801 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death pril 23, Physician/ WILLIAMSON CARL Α. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 4202 58TH AVENUE # 131 BLADENSBURG Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) SEPT Day Days Hours T950 VIRGINIA Director 224-76-3448 Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No PRINCE GEORGE'S BLADENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20710 4202 58TH AVENUE # 131 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Mental Hygiene. PRIVATE TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ANNIE L. AMOS MARVIS H. WILLIAMSON permit. Page 1 and 2 should by Department of Health and Men Important; If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12306 SNOWDEN WOODS ROAD LAUREL, MARYLAND 20708 BARBARA HENRY/SISTER 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) HARMONY CEMETERY 4/28/11 LANDOVER, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a, Part 1. # ter the di ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart fail Diabete of Physician/ dications disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the natural control of the Funeral Director. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural injury 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my online death occurred at the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Do 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) iled (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 22ay April 20 1ª1 2:00am M SR. AUSTIN WILLIAMS ELLSWORTH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 X M 2 🗆 F May 30, Year 945 579-56-6817 Yrs DC **Director** 65 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location the Maryland Director notified 28a-f 1 Yes 2 No MD Prince Georges Fort Washington 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 7004 Cherryfield Rd. 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Accountant Dept of Navy Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ John E. Williams Elaine Paskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fort Washington, MD 20744 Lena D. Williams - Wife 9014 Ridgewood Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 4-30-2011 Brentwood, MD 21. Signature of Eugeral Service Licensee Marshall-March Funeral Home of Maryland Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami signed by the attending physician and the detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Onknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy, performed? page 2 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: ပ္ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide completed filled in by the 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗗 🗲 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuzes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 45 am WEAVER Physician/ MARGUERTTE Medical 4b. City, Town, or Location of Death LANHAM 4c. County of Death
PRINCE GEORGE 4a. Facility Name (if not institution, give street and number) Examiner DOCTOR'S COMMUNITY HOSPITAL 8. Date of Birth (Month, Day, Year) 03-31-1928 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Social Security Numbe **Funeral** Days Hours Min Months ALABAMA 1 ☐ M 2x F 413-40-2641 Director 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov IId be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State Director items 23a or 28a-f s ner must be notified 1 X Yes 2 □ No PRINCE GEORGE GLENNDALE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20769 12405 RANSOM DR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces?
1 ☐ Yes 2 🗓 No 1 ☐ Never Married 2 ☐ Married "natural", or Specify: BLACK Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes Give 3 Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) PRIVATE CATERER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUCY HOUSTON EMMANUEL BRADEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7718 CARROLL AVENUE TAKOMA PARK, MD 20912 SHERRI SAMPSON/GRANDDAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition RIVERDALE, MD RIVERDALE CREMATORY 4-27-2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line.

Immediate cause (Final disease or condition) Approximate nterval Between eeks and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SAZARY SYNDROME Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit MYCOSIS FUNGOIDES Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical SEPSIS To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year in the past 12 months?
1 Yes 2 XNo Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 TV No certificate within 24 hours after death.

To the Funeral Director: After this certification completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 X Inpatient 2 DER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tyes မ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at 27. Manner of Death Certificate: (Month, Day, Year) work? injury 5 Pending X Natural 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one D22780 0 death (Item 23a) (Type, Print) 1500 breenway Ctr Dr Greenbelt, MD 20770 31. Date filed (Month, Day, APR 2 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #20b, 20c, 4-29-2011, per Fill Registrar PROPERTY PRO 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27^{ay} April 201 Tear Richard E. Wilson 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8929 Old Frederick Rd. Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 🔀 M 2 🗆 F Months 9^M20-1y336 213 34 9791 74 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 8929 Old Frederick Rd. 21043 United States , or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2x Married 1 X Yes 2 ☐ No If Yes, Give hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Social Insurance Specialist Social Security Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ဂ္ Francis James Wilson Blanche Arrahwanna Lahman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Helen V. Wilson/wife 8929 Old Frederick Rd. Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Gard. 5-3-2011

MO 1044

20c. Location - City or Town, State Condense of Facility Harry H. Witzke's Family FH Inc. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ö injury (4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee any Gellen 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death days Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Lung Cancer 30 days Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 2 🗌 No g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Physician; The law requires Alzheimer's dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? certificate has 1 ☐ Yes 2 ☐ No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year)

iot

State Registrar 31. Date filed (Month

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 28 2011

Kolodrubetz 8186 Lark Brown Rd Elkridge, MD 21075

Registrar's Signature

D31575

4/28/2011

11-03603 Yoon Kvuna An Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

boll Ryulig All		1-For State Critificate Certificate		Reg. No	. ZUII 13631
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death
ledical Exami		1001. 1(10019 111	4b, City, Town, or Location of Death	May 13, 2011	4c. County of Death
		Facility Name (if not institution, give street and number) Northwest Hospital	1	Baltimore County	
Funeral	-	Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24Hrs	8. Date of Birth(M	M/DD/YYYY) 9. Birthplace (State or
Director		215-47-2787 1□M 2XF 34	Yrs. Months Days Hours Min	02-25-19	Poreign Country) KOREA
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Aaryland 28a-f show 1 at once.	효	Maryland Baltimore Cat 10e. Street and Number	onsville 10f. Zip Code	10a. C	Citizen of What Country?
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and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahrrammatic event, the Medical Examiner must be notified at once	ᅙ		. Was Decedent of Hispanic Origin? (S		14. Race - American Indian, Black,
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21215-0036 ould be filed within 7 I Mental Hygiene, I marked other that ic event, the Medica	å	Unknown	ailing Address (Street and Number or	Oh	City or Town State Zin Code)
MD 2 nd 2 should the and M and 27 is m anumatic	은	1 1	303 Glenwilde Road		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.	ŀ	20a. Method of Disposition 20b. Place of D	sposition (Name of cemetery,		c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		Durial 2 X Cremation 3 Nemoval nom state	or other place)	16-2011	Baltimore Maryland
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876 ufficate ng phy as the l		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn		Month Day Year
Box 687; death certific.	Physician/	past 12 months? 4 ☐ Pregnant at time of death 5 ☐ 1 ☐ Yes 2 ☐ No 9 ✔ Unknown ☐ Unknown	Other (Specify)		
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Division of Vital Records, rat or Attending Physician: The law requir rs after death. *I Director: After this certificate has been s led in by the funeral director, page 2 should!	Be	25. Was case referred to medical	26.Place of Death (Check		
Vita hysici this c	TO B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa		ng Home 5 Resi	idence 6 Other:
n of ding Ph		27. Manner of Death 1 Natural 5 Pending May 13, 2011 28b. Tim 0630 hi	e of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	Subject hanged	i self
Sior Attend r death ector: by the	cati	2 Accident Investigation 28e, Place of Injury - At home, farm.		28f. Location (Stree	et and Number or Rural Route Number, City
Divi	Certification	Suicide 6 Could not be determined (Specify) Single Family Hon		or Town, State) 1303 Glenwilde R) Road, Catonsville, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause(s)	and manner as stated.
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated.			od. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		lay 14, 2011
		Charles of action of action (loss 201)	,		,
5		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 N	V. Baltimore Street, Baltimore	, MD 21223	
	tate	22 Desigtade Signature			
Regis	trar	THE TOTAL COLUMN TO THE PARTY		· · · · · · · · · · · · · · · · · · ·	
DHMH 17 Rev 1/2	2001	ORIG	INAL		OCME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF G916 6/09/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** WA 80: FU , 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltinou Haspital ltimore 0+ Sinai If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ADY 1 2 Birthplace (State or Foreign Country) 2T4-538-5409 6. Sex **Funeral** 1 □ M 2 Days Min. Hours Months Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experies or must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No by Funeral Director 77 now 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 201 No Baltimore, Maryland 21215-0036 1 ☐ Yes Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tronics WHICH BERTHENE 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle + 43 Be ၉ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Metflod of Disposition Date 20c. Location - City or Town, State 1 NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Licentee 21. Signature MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and atte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 55337 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ltimore 2401 MAHATARIN M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0308AM Harrison Bentley, Jr. 05 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore Franklin Square Hospital Rosedale 8. Date of Birth (Month, Day, April 0 Birthplace (State or Foreign Country) 24 Hrs. Min. 7. Age (In vrs. last birthday) Social Security Number Funeral Hours Year 1 🔀M 2 🗆 F Davs Months Director 225-30-9547 82 09.1929 Kentucky Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Rosedale 10f. Zin Code 10g. Citizen of What Country? 0 10e, Street and Number items 23a Funeral 6225 Golden Ring Road 21237 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White 3 Widowed 4 Divorced "natural" Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance M.T.A. Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Harrison Bentley, Sr. Stella Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Bentley (Spouse) 6225 Golden Ring Road Rosedale, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 18, 2011 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Holly Hill Memorial Middle River, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Eacility

Lyans Funeral Chapel & Cremetric

8800 Harrford Road Parkville, Mar

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line.

Immediate Cause Vinal disease or condition 22. Name and Address of Eacility
Evans Funeral Chapel & Cremetion Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Physician/ Card chemic disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IE EEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No certificate Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

3entley, Harrison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy C. Beierlein 13, 20 T May 4:19 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A Baltimore Good Samaritan Nursing Home g. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 □ M 2**X** F Jan. 11, 1929 216-24-8270 Months Days Hours 82 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 Funeral 1601 East Belvedere Ave. United States Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces2 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 Widowed 4 ☐ Divorced If Yes, Give Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Secretary Cole Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Nehmsmann Elizabeth Voqel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, and 2 s Health : Mrs.Mary Ellen Schiavo (Niece) 265 Valley View Drive Hanover, PA. 17331 item 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Location - City or Town, State (Harford County) Monday, Evans Fureral Charel and Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) May 16, 2011 Forest Hill, Maryland 21. Signature of Funeral Service Licens Lettrey L. Cair, S. O.S. 22 Name and Address of Facility S. Pineral and Cremetion Center, P.A.

Lic. #M0067 2325 York Road Timonium, Maryland 21093-2215 July July Lic. #M0067 Page In Alternatives Pure at any Lic. #M0067 Page In Alternatives Pure at any Lic. #M0067 Page In Thirdium, Mary Lic. #M0067 Page In Thirdium, Page In Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ALZHEIMER'S DEMENTA Medical resulting in death) Due to (or as a consequence of) Examiner CVP Sequentially list conditions, if my leading to cause. Enter Underlying Examine Due to or as a consequence of law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy To the Hospital or Attending Physician: The lawithin 24 hours after death.

To the Funeral Director: After this certificate he Completed filled in by the funeral director, page perform 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Natural injury М 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28987 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 3333 NI CALVERT ST

DHMH 17 Rev 7/2009

State

Registrar

7 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 11, Physician/ Steglia James Botto 2011 11:35р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3502 Benson Ave. Baltimore 5. Social Security Number 8. Date of Birth Aug. 12, 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ፟M 2 □ F Months Hours Country) PA **Director** 160-14-2639 90 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Baltimore MD 1 A Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a c Funeral Page 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 3502 Benson Ave. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ^{2 No} WW II 1 Never Married 2 🙀 Married by 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Distillery Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lupo Botto Vincenzia Pierino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Mactavish Ave., Baltimore, MD 21229 Jeffrey J. Botto (Son) : If item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Loudon Park Cemetery 5/17/11 Baltimore, Maryland 4 □ Donation 5 🛣 Other (Specify Entombment 21. Signature of Funeral Service Licensee 22 Home and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CHRONIC MYELOCYTIC Medical resulting in death) CARDIO VASCULAR DISEASE Examiner ATHEROSCLENOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) HRONIC KIDNEY that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22832 05-12-2011 Mus SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) MAIN STREET ELKRIDGE, MD 21075 SOON JA M.D 5808 Kin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav BATTAGLIA DEBRA AM 1:57 MAY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Augonth 26, Year 1952 1 M 2 D Maf%Tand 58 215-60-3690 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified Glen Burnie MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with USA 400 4th St. N.W. 21061 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ori ρ 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give Page 1 and 2 should be filed within 72 hours after 3 Baltimore, Maryland 21215-0036 Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Care Giver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) Maves Grace Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 400 4th St., N.W., Glen Burnie, MD 21061 Phillip H. Battaglia, Jr. (HUsband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 Removal from State 4 Donation 5 Other (Specify) = 5 cemetery, crematory or other place)
Loudon Park Cemetery Important: If any injury or BAltimore, Maryland 5/18/11 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Linease 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ STAGE LUNG disease or condition resulting in death) IV CARCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown detached 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2(1 No မ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 9 VISHAL VASAVADA 001 MAY, 14, 2011 '5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISHAL VASAVADA 21225 MD HANOVER BALTIMORE SOUTH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

7 2011

32. Registrar's Signature

11-035-97 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Brown-Bey 006fM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Sounty of Death **Examiner** umma Baltmore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Poreigr **Funeral** 1 XM 2 - F Months Days Hours 0671871944 Country) **Director** 66 219-42-5348 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland notified at Directo Baltimore n/a MD 1 ☐Xes 2 ☐ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ?7 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 21215 7020 Park Heights Avenue APT E6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Recovery & Outreach Counselor Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Henrietta Brown ပ Leroy James Speaks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 302 Haverhill Rd Joppa, MD 21085 Wendell Speaks- Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Ardent Crematory May 16,2011 Hanover, MD 21. Sign sture of Funder Sorbic John L. Williams Funeral Directors, P.A. 4517 Park Hgts Ave Baltimore, MD 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Days Immediate Cause (Final disease or condition Onset and Death Ph sician/ tematon Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month Day 4 🔲 Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law has autopsy performec 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗘 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Fall 5/5/11 2 No *Accident Investigation Unlinean 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Bus step Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

66

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of Health and letrificate of Death	Mental Hygi	2011 15665
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	eg. No. U JOOJ
Physician/ Medical Examiner			THOMAS Baker		Month 5	Day Year 1755
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
ممدريه.	Formula		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Laure It Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's 9. Birthplace (State or Foreign
	Funeral Director		204-22-0134 1 M 2 G F 82 Yrs	Months Days Hours Min.	May 9	Year) 1929 Pennsylvania
	d ow t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	1Non		10d, Inside City Limits
	arylan a-f sh fied a	Director	MD Prince George Laurel	Location		1 ☐ Yes 2 🖾 No
	the Ma or 28 e noti		10e. Street and Number	10f. Zip Code	11	0g, Citizen of What Country?
	s 23a rust b	Funeral	14709 Bowie Road, #203	20708		U.S.A.
	death r item iner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 1951-53	1 ☐ Yes 2 🛛 No Specify:		Specify: White
2-0	hour hatur	Completed	15. Decedent's Education 16a. De	ecedent's Usual Occupation ive kind of work done during most of wor	king	16b. Kind of Business Industry
121	within 72 giene. ner than '	om	Elementary/Seconday (0-12) College (1-4 or 5+)	o. DO NOT use retired)	ung	Horac Pagina
d 2	filed wil al Hygie d other went, th	To Be C	11 Rac	cing Secretary 18. Mother's Nar	ne (First, Middle, M	Horse Racing
lan,	ould be fill nd Mental marked o		Thomas Jefferson Baker, Sr.	I	le Gibson	,
Maryland 21215-0036	should be file and Mental I 7 is marked c raumatic eve			ailing Address (Street and Number or Ru		
e,	and 2: Health tem 27			D. Box 291, Laurel,		d 20725 20c. Location - City or Town, State
nor	age 1 ent of nt: If it y or o		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, of	crematory or other place) del Crematory May		•
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenters	22. Name and Address of Facility Donaldson Funeral		
Ω	B B E B B		Wolff MO0773	313 Talbott Ave. I	aurei, M	aryland 20707-4389
23a. Part 1. Enter the offsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Due to lor as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						Interval Between Onset and Deati
8760	ificate be executed ng physician and as the burial-transit	Medical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last c. Due to (or as a consequence of): d			
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total the funeral director.		23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ds, P.C	requires that the de been signed by the should be detached	ted by F	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		acco use contribute to the cause of death?
Division of Vital Records,	The law recate has be page 2 sho	Comple			24a. Was an autops perform 1 Yes 2	
ital	sician certifi irector) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I position: 2 PR/Output	26. Place of Death (Che	The Parkets	
of V	g Physer this seral d	te: To	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury at	ome 5 L Resider 28d. Describe how	nce 6 Other (Specify) w injury occurred
on o	ending sath. or: Afte	ficat	1 L Natural 5 ☐ Pending (Month, Day, Year) injut	y work? M 1 Yes 2 No		
ivisi	l or Att after d Directs I in by t	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
Ω	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the basis of my knowledge, dear	vestigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
	,		COOR THURN NEWS	m.a. D5422.	>	5/12/2011
	1021		30. Name and address of person who completed cause of death (Item 23a) (Type Tkuku Vayer, M.D.	e, Print) Laurel Region 7300 Van Dus	al Hospit en Road	al, Emergency Dept. Laurel, MD 20707
State Registrar 31. Date-filed (Morth, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 7.128 M Physician/ KIWIE 0 5 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Baltemore (enBr Livma mmyn, L If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Mumber **Funeral** Month, Day 1 M 2 F Months Days Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantical Formics. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code the Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc Specify. BLAC 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) HOME IMPROVEMENT College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ city or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Tuneral Servi . Liv nse 22 Name and Address of Facility 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Cerebra Physician/ VASLULAr disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 115723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21218 Blue. 170 3900

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MAGDELENE BUSENSKY 1041 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHOSAPEARS MODER CONDA HARFERD 52 DER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Country) MD 1 □ M 2 👿 F 06-14-1938 Months Days Hours Min. 219-26-5049 72 **Director** Usual Residence of Decedent 28a-f show 10a, State the Maryland 10c. City. Town or Location 10d, Inside City Limits Director Examiner must be notified 1 Yes 2 X No MD Harford Bel Air 10e. Street and Number ö 10f Zin Code 10g. Citizen of What Country? Funeral 23a 1308 Scottsdale Drive Unit M 21015 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give 3 Widowed 4 Divorced White Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Mental Hygiene. 12 Supervisor Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked ပ Edward Louis Businsky Sr Marion M. Stamm Health an n 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Businsky (Brother) 12 Minick Ct Nottingham MD 21236 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Red. Cem. D5-19-2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Du D. I Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PU MONARY UBABL disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Other (specify) Month Year Pregnant at time of death 9 Unknown the detached 9 Unknown ģ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy performed? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d, Date signed (Month, Day, Year) Name and address of person w completed cause of death (Item 23a) (Type, Print) DV 10 UPPER CHOS ABARO MAN JOR CONDER Registrar's State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14,2011 2022 George Alan Badey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake BelAir 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 12-4-1938 New York 72 Director 108-30-1189 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No N.C. Chocowinity 10e. Street and Number 10g. Citizen of What Country? 6 10f. Zip Code ms 23a or must be r Funeral USA 27817 104 Toms Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygien marked other t 12 Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Katherine King George Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
49 Hayley Hill Drive Carmel, New York 10512 49 Hayley Hill Drive Alan Badev Son Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 5-18-2011 Greenbill, NC. 4 Donation 5 Other (Specify) Rouse Mortuary 21. Signature of Funeral Pervio Licensee 22. Name and Address of Facility Schimunek Funeral Home · D 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiogonic disease or condition resulting in death) Medical Due to (or as a c ns quence of) Examiner cardiac Sequentially list conditions, it also be a sequentially to immediate cause. Enter Underlying Examine anoxic Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical myocardia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Anatural injury 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionary To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionary To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionary To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause(s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the cause (s) and manner stated Certifying Nurse Practical Properties of the Certific Properties of t (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065421 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive, Bel Air, MD 21014 NO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g915 5-19-11 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 15,2011 Eugene Bradley 5:30A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4407 Ebenezer Road Nottingham Balto. 5. Social Security Number .Sex 1 M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours August 31,1926 Maryland **Director** 216-20-7338 84 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🏋 No Md. Balto. Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4407 Ebenezer Road 21236 11SA Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 No
If Yes, Give 10// Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. P 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give 1944 - 1946 Year or Date 1944 - 1946 Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alexander J. Bradley Eulalie Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Bradley Son 207 Bucket Post Ct. BelAir, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5-19-2011 Dulaney Valley Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Service Lens Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair road Nottingham, Md. 21236 tex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death 2HOUS Physician/ 61 disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Examine Exist to for as a nonsequence cry cause. Enter Underlying use as the burial-transit Cause (Disease or iiniun that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Doth 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of emifier 29c. License number 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elwood Milton Blades Day 011 Year May 13, 7:10 P M Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice 4b. City, Town, or Location of Death **Examiner** 4c. Count Baltimore If Under 1 Year If Under 24 Hrs. Birthpic Country) MD 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 216-38-7926 Hours 1 DM 2 DF Months Days Min. 70 **Director** 10/ Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State MD 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits Director Baltimore Essex 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 21221 USA 149 Hampshire Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 \(\square\) No \(\text{Army} \) Black, White, etc. þ 1 Never Married Married Baltimore, Maryland 21215-0036 Yes 2 XNo Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Air For 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) tr of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the ME Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Shipyard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ೭ Elwood Milton Blades Thelma Salisbury 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hampshire Road, Essex, MD 21221 Joan Blade / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 X Cremation 3 Removal from State 5/18/2011 Final Yourney Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_{sician} disease or condition MULE Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 NO Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the cause(s) and manner stated. 29b. Signature and tipe of certifie 29c. License number 29d. Date signed (Month, Day, Year) MA 71046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR 6701 BALTIMORE N CHARLES ST 4105 SUITE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of Death	Reg	No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Neil E	Proun		2. Date of Death Month [May 1, 2011)ay Year	3. Time of Death 1810 hrs
		4a. Facility Name (if not institution, give s 4219 Dressage Court	treet and number)	4b. City, Town, or Location of Death Randallstown	1	4c. County of Death Baltimore Cour	nty
Funeral Director		5. Social Security Number 6. Sex 214-94-3967 1 MN	7. Age (In yrs. last bir	Mantha Dava Hours Mir	_	MM/DD/YYYY) 9. Birth Foreign Cou	place (State or htry) Mary I grad
land f show any once.	tor	10a. State 10b. County Maryland	10c. City, Town	Randallstown			10d. Inside City Limits 1 Yes 2 No
n the Maryland 3a or 28a-f show otified at once.	I Director	10e. Street and Number 4219 Dressage	d	10f. Zip Code 2/133	10g	Citizen of What Count.	ry? -
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? Yes 2 No Yes, Give Yeer Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:		14. Race - Americ White, etc. Specify:	an Indian, Black,
TOTE, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		6b. Kind of Business/In	dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last)		Leanna	Foderil		
ore, MD 2's and 2 should be the aith and Mc If item 27 is mather traumatic or	۵[19a. Informant's Name/Relationship (Typ Melissa Brown	-wife .	b. Mailing Address (Street and Number or 4219 Dressage Ct.	Kanda	Istown, Na	ryland
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other to injury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Fyneral Service License	Removal from State	of Disposition (Name of cemetery, tory or other place) Memorial Park 3 22. Name and Address of Facility Par	116/11	Randallstown	Maryland
Balti Permit Departing Import		fevin far	Ker	3512 Frederick A	M. Baltin	work Mary	Approximate Interval
/Medical :xaminer							Between Onset and Death
	iner	cruse Elter Underland Cause	e to (or as a consequence of):				
uted nd ransit	Examine	(Disease or injury that initiated events resulting in death) Last Du	e to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical		AMENDED 23c. If yes, outcome of pregnancy			23d. Date of delivery	
	Physician/R	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	ancy	Month Da	y Year
P.O. E es that the digned by the be detached	Completed by Phy	Part II. Other significant conditions co	ontributing to death but not resultin	g in the underlying cause given in Part I.		cco use contribute to the	
Division of Vital Records, P.O. Box 68' for the Bospital or Attending Physician: The law requires that the death certification of the Bosoma after death. To the Fuorral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I					24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of
Vital Rec ysician: The l his certificate b director, page	8	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ER/O	26.Place of Death (Check outpatient 3 DOA Other Nursin		esidence 6 🗸 Other:	Scene
n of V ding Phys	وا ا	27. Manner of Death	28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe hove Subject shot s	v injury occurred	ocene
Divisior Septial or Attend hours after death toeral Director: y filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	May 1, 2011 164- 28e. Place of Injury - At home, for	4 hrs arm, street, factory, office building, etc.	or Town, Stat	eet and Number or Rura e)	
Di To the Hospital of within 24 hours a. To the Fuoeral I	edical Ce	4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: 0	n the basis of examination and/or i	ownouse ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(s		i.
To the within 2 To the complet	Med	29b. Signature and title of certifier	nd manner stated.	29c. License number		9d. Date signed (Mont	h, Day, Year)
	-	30. Name and address of person who cor	npleted cause of death (Item 23a)	O.C.M.E.		May 2, 2011 	
1		· · · · · · · · · · · · · · · · · · ·	lur e	W. Baltimore Street, Baltimore, M	D 21223		
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Kel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical May^{Month} 13, 201¹ € 9:05 Р. м Catherine A. Craig 4a. Facility Name (if not institution, give street and number)
Stella Maris 4b. City, Town, or Location of Death TOWSON 4c. County of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Social Security Numbe 214-26-8278 1 M 2 XXF Days Hours January 12 (ear) 1929 Marvland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Rogers Fordge 1 Yes 2 X No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21212 USA 417 Murdock Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary Seconday (0-12) College (1-4 or 5+) Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine A. McCosker Samuel A. Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Murdock Road Rogers Fordge Maryland 21212 Mary Regina Craig/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State New Cathedral Cemetery 5/17/11 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) leonardangAddrisser Facility 5305 Harrord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final STAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Source tielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ြုင 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Their CRM 05-16-2011 R 04358D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JUSTINE PREIS, CRNP

31. Date filed (Month, Day, Year) MAY 1 7 2011

MAY

CRAIG

CATHERINE

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Year Physician/ Month 8:20 A M May 14 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Months 217-40-229 Director important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married Married
3 Divorced Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Year or Dates. 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) reelauce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) Method of Disposition Burial 2 Cremation 5 Other (Specify) Burial 2 Cremation 3 Removal from State 21. Signatury of Fun ral Service License such as cardiac or respiratory arrest Enter the disease, or complications that caused the death. Do not enter the mode of dvin Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer rancreatic disease or condition 2 months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Dav the P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature as D0043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Bohner 6535 A N. Charles St. Brian 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 140 60 /Medical 4a. Facility Name (If not institution, give street and number) 4c. Gounty of Death Examiner 7 m 60 14lus WUUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Manth, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last, birthday) **Funeral** Months Days Hours 1□M 20 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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(Give kind of work done during most of working life. DO NOT use retired)
Executive Evrector of Spear Ceviter 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kouse Co. 2 years 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tucker Pavell Willie Chestine 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5849 Harpers Farm Road Columbia MD 21044 Chestino Johnson Dallahter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Cremating 05/19/ Baltinone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Struct 21. Signature of Funeral-Gervice Licensee 8728 Liberty Road Randal bown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sw h as cardiac or respiratory arrest, shock, or h-iart failure. List only one cause on each line.

Immediate Causa (Fr al disease or condition) Approximate Interval Between Onset and Death **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner 94016 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 2 🗆 No 1 □ Yes 1 🗆 Yes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours e Funeral 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Pwithin 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Hickory Ridk

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARLOWMD 1080S

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:26PM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 8-14-1925 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Yrs. 219-14-0768 85 MD **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Dundalk 1X Yes 2 □ No Director 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? 241 Baltimore Avenue 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: <u>م</u> Specify: White WWII 3 Nidowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator q American Yeast Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Joseph Cusimano Unknown ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |Mary Hoxter - Niece 2304 Putty Hill Ave., Baltimore, MD 21234 Health em 27 I permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State Atlantic Crematory 5-16-11 Glen BUrnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral HOme 21. Signature of Funeral Service I PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 2 No After this certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 \square Nursing Home 1 Yes ER/Outpatient 1 Inpatient 3 🗀 DOA 5 Residence 6 ☐ Other (Specify) ည 28a. Date of Injury (Month, Day Year) Manner of Peath ₽8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury Natural 1 Tyes 2 🗌 No Accident the Director Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224

Registrar

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month May ^{Day} 2011 13 Robert Joseph Cangelosi 2:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 1 🛛 M 2 🗆 F Hours 218-38-7883 Yrs. October T, 1940 New York **Director** 70 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No Maryland|Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15117 Water Oak Drive 20878 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 K Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Food and Drug Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Electrical Engineer Administration traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Cangelosi permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. Clotilda Patricia Castorina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15117 Water Oak Drive, Darnestown, Maryland 20878 Ann E. Cangelosi / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Darnestown Presbyterian 4 ☐ Donation 5 ☐ Other (Specify) May 17, 2011 Darnestown, Maryland Church Cemetery Name and Address of Facility
Pert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc.
57 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Ph_sician/ Mesothelioma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leaching to him cital cause. Enter Underlying Doe to forms a consectionne off-Examin or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and tra Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 2 X No မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🛚 Natural 5 Pending work s after death. 1 🗌 Yes 2 🗌 No the 1 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

С.

Bindu

Joseph, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Si

30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print)

29c. License number D60634

May 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month $1^{\square_3^{y}}$ 2011 5:05 P M Chen Hsin Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 X M 2 🗆 F (Month, Day, Year) November 25 China China Yrs **Director** 219-94-1742 93 1917 Usual Residence of Decedent show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Silver Spring Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 38 Baileys United States Court 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Specify. Completed Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Airplane Mechanic Airline traumatic event, Be permit. Page 1 and 2 should be filed i Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Zue Chen Ma Chen Jiang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13909 Bergenfield Drive, North Potomac, Maryland 20878 Jane Chen / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, May 20, 2011 | Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Li Robert A. Pumphrey Funeral Home/Rockville, Inc 1300 West Montgomery Avenue, Rockville, Maryland 20850–2805 the th M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph.si.ian Colorectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ☐ Pregnant at time of death
☐ Unknown in the past 12 months?

1 Yes 2 No Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s death? certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After X Natural injury 5 Pending hours after death. Ineral Director: Ai 1 Tyes 2 🗌 No filled in by the Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed within 2. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

State Registrar <u>Joseph</u>

31. Date filed (Month, Day, Year)

Bindu,

MAY 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D0060635

6001 Muncaster Mill Road, Rockville, Maryland 20855

May 13, 2011

Raelynn	Louise	Coleman	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Raelynn Louise Co	1- For State Registrar Certificate of Death Reg. No. 201	5 6 7 1 3. Time of Death
Physician Medical Examine	Month Day Man	1253 hrs
	4a. Facility Name (if not institution, give street and number) 7314 Martell Avenue 4b. City, Town, or Location of Death Baltimore Baltimore Cou	
Funeral Director		
varyland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore	10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street and Number 11411 Stengel Avenue 10f. Zip Code 21222 USA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f ahe traumatic event, the Medical Examiner must be notified at once To Ro Commissed the European Directors.	3 Widowed 4 Divorced it is side Year 1 Yes 2 No specify: Specify: Specify:	ican Indian, Black,
5-0036 ed within 72 hours lygiene. other than "natus the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk Banki	ŕ
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Raymond Baker Coleman Jacqueline McLyman	
MD 21 ad 2 should lith and Me n 27 is ma numatic ex	Lynn Coleman / Mother 41 Topeka Road, Conovingo, MD 21	918
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, ror other place) Final journey crem. 20c. Location - City or 5/13/2011 Woodbine,	·
	21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 2	1203
Physician /Medical £xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease) a Amitriptyline intoxication	Approximate Interval Between Onset and Death
i d	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
led nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, are be executed bhysician and bunial - transit		
certific	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	Day Year
P.C es that es that igned		
of Vital Records, P.O. Box g. Physician: The law requires that the death ther this certificate has been signed by the atteneral director, page 2 should be detached for I. To Be Completed by Physician:	24a. Was an autopsy prior to comperformed? 1 ✓ Yes 2 No 1 ✓ Ye	topsy findings available ompletion of cause of
Vital Recysician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)	
ing Physical Interpretation of Victorial Interpretation of	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 3 Versing Home 5 Residence 6 Other.	Scene
endir ath.	1 Natural 5 Pending fd 5-7-11 fd 12:45 pm 1 Yes 2 X No unknown	
0 \$ 5 5 9 C	2 Accident Investigation 3 Suicide 6 X Could not be determined Specify Residence Specify Residence Specify Sp	al Route Number, City
Divi To the Hospital or. within 24 hours after To the Funeral Dir completely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state one of the cause (s) and manner as state one	
T T W W W	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Months) May 8, 2011	th, Day, Year)
5	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 20c per fh,g915,05/17/2011dhb

Reg. No. 1 - For State Registrar 5680 Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:23AM Doese 2011 Margaret Medical 4a. Facility Name if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Secours Hospa If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Country Months Days Hours 1 🗆 M 2 🗷 F 212-22-242 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other them. 10b. County 10a. State 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U54 GROVE St. 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married 2 No ☐ Yes 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry /Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17-Father's Name (First, Middle, Last) ၉ Informant's Name/Relationship (Typle, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Laurel, MD 4 ☐ Donation / 5 ☐ Other (Specify) 212,29 21. Signature of Funeral Service Licen Kass Bosto Mb 23a. Pa 1 proof the sease, or complications that caused the death. Do not enter the mode of dying, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate O use (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 7 Cause (Disease or iinjury that initiated events resulting in death) Last page 2 should be detached for use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant 5 Other (specify) Pregnant at time of death g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 🗀 No Certificate: To DOA 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 1 Natural iniurv 5 \square Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

State Registrar 2000 W

Baltimore street,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-12-2011 1245 P M Helene Dorothy Dunch Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Hours 07 - 14 - 1927 83 NJ 136-20-5172 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Harford 1 Yes 2X No Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 21014 USA 1 Linwood Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 X Married 2005/12/11 7005/24 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholas Bagley Rose Hornyak Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linwood Ct Bel Air, MD 21014 Joseph B. Dunch (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gardens 05-17-2011 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland re f Funeral Service Aceris 22. Name and Address of Facility Schimunek Funeral Home of BelAir c10 W. MacPhail Rd BelAir, MD 21014 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OCOCCA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 the as yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ 1 Expatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Vatural injury 5 Pending Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) D0053568 May 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesa peaks Drive Bel Air Maryland HEMPSON

DHMH 17 Rev 7/2009

State Registrar egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 7 2017 WILLIAM (NMN) DINKA 9:49 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace Date of L... (Month, Day, Ye Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min 218-18-9089 New York Director 85 Aug. be filed within (2 110cm.)

Aental Hygiene.

arked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 23a or 28a-f show arked other than "natural". Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Cecil Port Deposit 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1842 Frenchtown Road 21904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F John (nmn) Dinka Megdelena (nmn) Machlica permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Thurston / Daughter 1842 Frenchtown Road, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp 5-11-11 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[™] No မ 1 🗌 Inpatient 2 📉 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 5 \square Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3225 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIS W. MO. Bel Air, Maryland 21014 DAVED 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 22 per FH, G9 15, 5/17/2011 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 9, 2011 11:00 A^M John Francis Emm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 28 Allegheny Ave Towson 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 28, 1932 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. West Virginia 212-30-6959 79 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2🏋 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 28 Allegheny Ave Apt. 1005 12. Was Decedent Ever in U.S.
Armed Forces?

1X Yes 2 \sum No 1950
If Yes, Give
Year or Dates. 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: White Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Driver Freight Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fred A. Emm Irene E. Mosher e 1 and 2 should of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 311 Tiree Court Unit 104 Abingdon, MD 21009 <u>Marv Ellen Schmidt, Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Crematory Inc. 05/10/11 Baltimore, Maryland Cremation Society Of Maryland, 1050 York Road Towson, Maryland 21204 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service License Thomas Gregor 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Immediate Cause (Final unte Onset and Death intarction myocardial Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ prostate 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID. D0055157 2011 Ox\ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore St 21201 Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature 7 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13. 0830 2011 ARLENE EPSTEIN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE NORTH OAKS HEALTH CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. 09/22/1928 104-20-1337 Director 82 NY Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 ី No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 725 MT. WILSON LANE, APT. 311 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ HOROWITZ THELMA HYMOWITZ SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE, APT. 311, BALTIMORE, MD 21208 ELLIOTT EPSTEIN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONGR. 05/15/2011 FINKSBURG, MD 22. Name and Address of Facility 21. Signature of Funeral Service SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final Physician/ lascular demention disease or condition Paus Medical resulting in death) Due to (or as a consequence of Examiner Atherosalevotic Jascu| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 13, 2011 30. Name and address of person pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Baltimore

MD

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Silzell

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Jef

31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day May 5, 2011 2220 hrs **Medical Examiner** David I-rank 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 664 Cecil Avenue N Millersville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Director 213-80-1669 1 M 2 F Country) Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 1 Yes 2 No A.A. illersville 23a or 28a-f show notified at once. Mι permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be norified at non-Director 10g. Citizen of What Country? 10e. Street and Number 21108 664 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married 1 Yes 1 Yes 2 No specify: 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 la Dailor 18.Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (First, Middle, Last) Franklen Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bowita 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 1 Burial 2 Cremation 3 Removal from State crematory or other place tanover Hydent Donation 5 Other Specific 22. Name and Address of Facility the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** Between Onset and Medical Death a Cardiac arrhythmia due to cardiomegaly Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, pt. II, 27, per me, g915 5-25-11 sm X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcohol abuse Completed page 2 should After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28a, Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 5 Pending 1 Yes 2 No death. Director: d in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) within 24 hours at Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 6, 2011 Drasse, 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

OCME 2006

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4c, perPHYS#10b, perINF, G917, 7/6/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mary Angela Frederick Month 14 Pay 2019 11:45 AM Medical 4c. County of Death Harford County
Baltimore County Facility Name (if not institution, give street and number) n, or Location of Death **Kingsville Examiner** 4b. City, Town 2505 Longview Drive 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 22, 1949 Davs Hours Min Baltimore, MD. Director 61 Yrs. unk. Usual Residence of Decedent Harrord County 28a-f shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Baltimore County Kingsville 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code Citizen of What Country? United States 21087 Completed by Funeral 2505 Longview Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White 'natural", Specify: 3 Widowed 4 Divorced if health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Administrator Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Margaret Elizabeth Kuhn ည Robert Joseph Geier, Sr. 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2505 Longview Drive Kingsville, Maryland 21087 Mr. Dennis Earle Frederick 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Sunday, (Harford County)
May 15,2011 Forest Hill, Maryland Department of H Important: If ite any injury or ot Evans Fursain Cretter and Crenation Services, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Jeffrey L. Gair, Sr. U.S. 22. Name and Address of Facility Executives Funeral and Cremation Center, P.A.

Peacetul Alternatives Funeral and Cremation Center, P.A.

21. Signature of Funeral Service License Jeffrey L. Gair, Sr. U.S. 22. Name and Address of Facility Executive Means of Facility Execu 2325 York Road Timonium, Maryland 23a. fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) enan Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 IF FEMALE: Jse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year 4 Pregnant a Pregnant at time of death detached Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law wittin 24 hours after death.

The Funeral Director: After this certificate has be the Funeral Director. autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 140 ည 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ag title of certifi 29c. License number 29d. Date signed (Month, 7106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI ICUM N HARL 13 5 31. Date filed (Month, Day, Year) MAY 1 7 20 204 State

Registrar

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arka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :49 AM Nancy Fogle Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arunde Burnie Baltimore Washington Medical 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) 11-27-1933 Country)
Marvland Days Min. 1 □ M 2√ F Director 215-30-7068 shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10a, Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be n Funeral United States 21061 104 King George Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 X No Specify. WHITE 3 ₩ Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12th grade Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delores Taylor Thomas Ryan Davis injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2278 Canteen Circle, Odenton, Maryland 21113 Dawn Lockwood - DAUGHTER altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-13-2011 Baltimore, Maryland Metro Crematory INC Funeral Service Licensee Patrik Fleming ^{22. Name and Address of Facility}Cremation Society OF Maryland INC 299 Frederick Road, Baltimore, MD 21228 Sonature em 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death n ead Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner 40 LAGINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown the a signed by the 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖵 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Retifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29b. Signature and title of certifie 2053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUEN BURNET ME ALIMONO MSa Sour 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:29 James Michael Flint, Sr. MA' Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. 8. Date of Birth
| Hours | Min. | (Month, Day, Year) | Oct. 25, 1954 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Maryland 56 Yrs. Director 214-62-6064 Usual Residence of Decedent · 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City 1 ¥2 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? or items 23a Funeral 21229 3707 Greenvale Road United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. 1 Never Married 2 X Married þ within 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Magninjury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) 9th N/A Supervisor Manufactory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Trossill Joseph Flint 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 Greenvale RD., Baltimore, Maryland 21229 19a. Informant's Name/Relationship (Type, Print) Kathy Flint /Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory, LLc May 14,201 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Signature of Funeral Service Licensee 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician METASTA disease or condition VE 1721 Medical resulting in death) Due to (or as a consequence of Examiner Eagus flally liet on dillone, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗖 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. CATON AVE Revoul

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Edward 2011 Fortuna 2:45 AM 14 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 729 Edmund St Harford Aberdeen Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 / 0 5 / 1 9 2 7 Months Days Hours Min. New York Director 084-20-7584 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Aberdeen 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 729 Edmund St 21001 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 X Married Completed by 2 No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. 1948-71 "natural", 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Soldier Military 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Fortuna Barbara Czerwonka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Fortuna / Wife 729 Edmund St, Aberdeen, MD 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Harford Mem. Gdns 5/19/2011 Aberdeen Other (Specify) 21. Signatur of Fur ral Service Tarring-Cargo Funeral Home, 333 S. Parke St, Aberdeen, M P.A. 4D 21001 sancy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final bladder carcinona Physician/ metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitally list and discussifiany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria /Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed Lung cancer 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Atrial Fibrillation certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\triangle \) Nursing Home \(\triangle \) Residence \(6 \) Other \((Specify) \) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000048050 5 16 11

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DHMH 17 Rev 7/2009

State

Registrar

15 S. Parke St. # 400 Aberdeen MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prashant Shukla

MAY 17 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 2011 12 Rita Catherine Gerhardt 8:12 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20 Box Hill South Pwky Apt. 119 Harford Abingdon If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🌠 F Months Hours July 8, 1925 85 217-20-3553 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Abingdon 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Box Hill South Parkway Apt.119 21009 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Administrator Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Karl Kraft Marie Louise Schepers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Christine Gerhardt-daughter 3200 Upperco Court-Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite Holy Redeemer 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 May 16,2011 Baltimore, Maryland injury Cemetery 21. Signature of Funeral Service Licensee any in Fadol Evans Funeral Chapel and CremaTION Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death ORONAMA Physician. MEDINS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transi Exami Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: Live Birth 2 Fetal death use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for Month Day Year the funeral director, page 2 should be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 ☐ Yes 2 ☐ No 2 🕝 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 Tes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Man of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending (Month, Day, Year) 1 Natural 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and and dress of person who completed cause of death (Item 23a) (Type, Print) Writ MACPHAIL RO ANUS LIMAD 615 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year e 6 7:02 M MA Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ot Maryland Medical Center altimore University Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ F (Month, Day, Year) Jan. 5, 1944 Months 42 Director DC Usual Residence of Decedent Show 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George 1 X Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14112 Greenview Drive 20708 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Automotive Racing Elementary/Seconday (0-12) College (1-4 or 5+) Headers Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert L. Gebler, Sr. Geneva L. Chelini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marines L. Gebler/ Wife 14112 Greenview Drive, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 14, 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Burtonsville, MD Union Cemetery 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. L. Kein Skile M01053 313 Talbott Ave., Laurel, MD 20707 Pbd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Je Cr otizina disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PSIS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown ed by the a g Unknown cate has been signed? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 X Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗆 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 2011 MO 10 OX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grieshober - University of Maryland Medical Center MD 32. Registrar's Signature Registrar

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				For State Registrar	State of Ma	-	epartme <i>Certifica</i>			-	giene Reg. No.	01	15692
		Physicia Medi		1. Decedent's Name (First, Middle, Gerald; ne	Virginia	Gira	ry			2. Date of Dea	-	20TI	3. Time of Death 12: 09 A M
		Examir		4a. Facility Name of not institution, 9			4b. Ci		ocation of Death		4c.	County of Death	
4M		Funeral Director				(In yrs. last birth	day) If Und Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	196	9. Birth Coun	place (State or Foreign
: OG AM		with the Maryland \$ 23a or 28a-f show ust be notified at	Director	10a. State 10b. County		10c. City, Town	or Location	2					10d. Inside City Limits 1
12		h with the ns 23a or 3 nust be no	Funeral D	10e. Street and Number 835 Wicklow	Road			Zip Code 212			10g. Citi;	zen of What Cou	ntry?
	9600	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates.		If Yes, sp	cedent of His becify Cuban s 2 No	panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify: Bl	
12	Maryland 21215-0036	within 72 hours after giene. er than "natural", or , the Medical Exami	Completed	15. Decedent (Specify only highes Elementary/Secoliday (0-12)			life Ø D NOT ι	vork done du	ring most of wor	king	Ba	chools	
5	yland (should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the Me	To Be		ge					ne (First, Midgle) Le la		Surname)	
		and 2 should Health and Me tem 27 is marl other traumati		19a. Informant's Name/Relationshi	Daughter	82		cklou	1/1	Baltin	nove	Town, State, Zip	21229
Giray	Baltimore,	t. Page tment o tant: If ijury or		20a. Method of Disposition 1 → Burial 2 □ Cremation (4 □ Donation 5 □ Other (Sp	ecify)	20b. Place of lemetery			5-19	Date 9-2011		Cation - City or T	e MD
G	Bal	permit. Departr Imports any inji		21. Sixa re of Funeral service Lic	J. Steer	ڡ	5151	Bal	to. Na	ene ti til Pik	e C	21229)
٦	Į	Physician/ Medical		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_ aLUN	the death. Do not be the death	ICER	ode of dying,	such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
がず		Examiner)r	Sequentially list conditions,	b. —								
eral		executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury that initiated events	Due to (or as a	consequence of):						
Be	09/		ā	resulting in death) Last	Due to (or as a	consequence of	f): 	_					
	Division of Vital Records, P.O. Box 68760	Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death certificate be 24 hours after death. After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Petal death	3				2	23d. Date of deli Month	very . Day Year
	P.O.	requires that the de been signed by the should be detached	by Pr	Part II. Other significant condition ATELAL F	0	0	the underlyin	ig cause give	n in Part I.				the cause of death?
	ords	v require s been s should	oleted	AT CIAL I	15 PICON	.ON				24a. Was	an	24b. Were auto	obably 4 Unknown opsy findings available
	Rec	sician: The law i certificate has b irector, page 2 s	Com		,					autop perfo 1 Yes	rmed?	death?	ompletion of cause of
	/ital	ysician; is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Other	e of Death (Chec				
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	ion	ttendin death. tor: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation		М	1 □ Y	es 2 🗆 No				
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		ne Hos n 24 ho ne Fund pleted	Medical	(Check 2 L Medical Ex	Physician: To the best of maminer: On the basis of exa Nurse Practioner: To the b	amination and/or	investigation, i	in my opinion	, death occurred a	at the time, date a	nd place,	and due to the ca	ause(s) and manner stated.
		To the I within 2 To the I comple		29b. Signature and title of certifier	^		2	9c. License			29d. Date	e signed (Month,	Day, Year)
1		•		30. Name and address of person wi		ath (Item 23a) (Ty	ype, Print)	0006			2/1	3/2011	
3	V			HASAN AWA	N 2717 H	AMMON	DS FE	YSX	RD B	ALTIMO	PE	MD 2	1227
		Stat Registra		31. Date filed (Month, Day, Year)	2011 32. Registrar	Signature	bar	2			/		

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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MAY 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY Pay 4 2011 3:23 P M ROBERT **GOLDMAN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE 17816 FORESTON ROAD PARKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 X M 2 D F Months Hours Min. (Month Day Year) 29 Country) Director MD 213-26-9461 81 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Me Jical Examiner must be notified at Director 1 Yes 2 No BALTIMORE PARKTON MD 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 23a 17816 FORESTON ROAD 21120 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. Hygiene. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Specify: Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR SOCIAL SECURITY 1 and 2 should be filed with f Health and Mental Hygier item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GOLDMAN DORA LICHTENSTEIN JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE E. LANG III/PERSONAL REP 17640 PRETTYBOY DAM ROAD, PARKTON, MD 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/16/2011 BETH TFILOH CONG. WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ō Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed Hospital or Attending Physician: The certificate 1 Yes 2 No 2 5KN 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2° 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time o Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 A Natural 5 Pending 2 Accident 1 Yes 2 No 24 hours after death Funeral Director: A Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ü 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and Westminster 31. Date filed (Month, Day, Year) 32. Recistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 11:45P M Hiram Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Joppatowne 237 Kearney Road 9. Birthplace (State or Foreign Country) Buren, Tennessee 8. Date of Birth (Month, Day, Y Scot. 25 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 🕅 M 2 🗆 F Hours Months 1931 Director 413-52-2046 79 Burem. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 XNo Joppatowne Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō United States and Mental Hygiene. Funeral 21085 237 Kearney Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates. 1951–1953 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) filed within tal Hygiene. Elementary/Seconday (0-12) Education <u>Teacher</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allie Belle Jones John N. Hurst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 237 Kearney Road, Joppatowne, Maryland 21085 Carolyn Hurst (Spouse) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel-Bel May 17, 2011 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel &
3 Newport Drive Forest Signature of Junera Cremation Services Hill, Maryland 2105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or interfailure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Lun unce disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions. Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes should I Completed been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performa 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's S

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Franklin Square Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month David Hopkins May 2011 3:51 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Harford Center 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In vrs. last birthdav) Funeral 213-88-4853 42 Months Days Hours Min. 1 🗶 M 2 🗆 F Maryland Director 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Examiner must be notified at Director Maryland Harford Bel Air 1 Yes 2X No 10f. Zip Code 21014 Street and Number 112 East Gordon Street Apt C 10g. Citizen of What Country? Funeral United States items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black. White, etc. ö 1 X Never Married 2 Married b 1 Xes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 'natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tele-Communications 12th grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Hopkins Connie Brock David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Connie Brode - MOTHER 107 Arbutus Drive, Joppa Maryland 21085 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-16-2011 Baltimore, Maryland OPKINS, Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland of Funeral Service Licensee Patrik FLeming 299 Frederick Rd, Baltimore, MD 21228 Part 1. Enter the disease, or complications that called shock, or heart failure. List only one cause on each line ed he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Odays Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical that the death certificate be P.O. Box 68760 nding L se as ti IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) P in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 Tes Division of Vital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ 1 Nopatient 2 Ser/Outpatient 3 DOA s after death.

I Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Aatural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сотретер (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier D0053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State of Mary		irtment of I tificate of I			0011	1 = 6 0 =		
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death						
	Physicia Medic		Hugh K. Holmes	Month May 1	6, 2011 Year	2:30 AM _M					
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o			4c. County of Death Baltimore			
	Funeral		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)	If Under 1 Year	Timoni If Under 24 H	rs. 8. Date of Birt	n g. Bii	rthplace (State or Foreign		
	Director		012 00 7000 4€]M2□E	92 Yrs.	Months Days	Hours M	in. <i>(Month, Day</i> January	(31, 1919 Ma	ryland		
	nd how at	r	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Loc	ation	-			10d. Inside City Limits		
	farylar 3a-f sl tified	Director	Maryland Anne Arundel	Pasadena					1 ☐ Yes 🌠 ☐ No		
	the Na or 20	Ē	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?		
	h with ns 23; nust l	Funeral	4485 Mountain Road		21122			United St	United States		
2:30 a.m. 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρχ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1★ Yes 2 □ No If Yes, Give Year or Dates.	If	Vas Decedent of H Yes, specify Cuba	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify: Whit	te, etc.		
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, 2011 Maryland	shoul and I	[4	19a. Informant's Name/Relationship (Type, Print)		•			; City or Town, State, Z	ip Code)		
16, re, h	and 2 Health em 27 ther t		Ann Marie Elsroad Daughter 20a. Method of Disposition 20	534 Ob. Place of Dispos		Road Se	evern, MD	21144 20c. Location - City of	Town State		
MAY 16, Baltimore,	age 1 ent of nt: If it y or o		X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	atory or other plac		Date 5/23/11	Glen Burn			
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1	7 = ==	iner	Sequentially list conditions, if any, leading to immediate Dause Frite Underlying Due to (or as a con	sequence of):							
1/18	ecuted and I-trans	Exan	Cause (Disease or iinjury that initiated events c	sequence of):							
09	ate be executed physician and the burial-transit	edical Examiner	d	, ,							
			IF FEMALE:								
HOLMES Box 687	th cert ttendir or use	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pre	Fetal death 3		су		23d. Date of de	blivery Day Year		
	ne dea / the a ched fi	ysic	1	e of death 5 ∟	Other (specify) _			Worth	Day		
HUGH s, P.O	that the ned by edeta	by Pł	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
	quires en sig ould b	ted l					_ 1 🗆 \	′es 2 No 3 ☐ F	Probably 4 🗆 Unknown		
COL	law re nas be e 2 sho	Completed					24a. Was a autop	sv prior to	utopsy findings available completion of cause of		
Re	r. The icate in page	Col	25. Was case referred to medical				1 🗆 Yes	med? death? 2 X No 1 Ye	s 2 No		
Vita	/sicial s certii directo	To Be	examiner? [Hospital:	2 ☐ ER/Outpatien	Oth	ace of Death (C		ence 6X Other (Spe	city HOSPICE		
H Division of Vital Records,	ding Phy h. After thi funeral (Certificate: T	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Injur work	y at		ow injury occurred	iny) HOOT TOIL		
isio	Atten er deat ector: by the	ırtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury-A			163 2 110		treet and Number or Ru	ural Route Number,		
Div	ital or urs afte ral Dir lled in		building, etc. (Sp.				City or Tow				
	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To with		29b. Signature and title of certifier)	29c. Licens	e number 19797	2	29d. Date signed (Mont 5 16 20	2.4		
	2+1		30. Name and addysss of person who completed cause of death (,			1			
	Stat	e	JACKIE JONES, CRNP 2300 DUL 31. Date filed (Month, Day, Year) 32. Registrar's Si		LEY RD.	TIMONIU	JM, MD 210)93			
	Registra		M / V 1 / / A A A A	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** UEENI NE 201 /Medical City, Town, or Location of Death Name (If not institution, give street and number) 4c. County of Death 4b Examiner 9. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday **Funeral** 213-20-823 Hours Min. Months Days 1 □ M 2 10 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or items 25a be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count 1 Yes 2 No Completed by Funeral Director HIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2516 212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 D No 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BIACK Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) omEstre HOUSE 1 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DNES 110 ONES P 19b. Mailing Address (Street and Number or Pur I Route Number, City or Town, State, Zip Code) 1/1/7 19a. Informant's Name/Relationship (Type. Print) 9020 GROffs WINGS MILS Me 20c. Location - City or Town, State NORMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 □ Cremation permit. Page Department of Important: If any Injury or once. nd National Mem. P 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ones, JR UNERALSVC 2/2/3 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final deBII ITY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as use IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year Po in the past 12 months? 1 □ Yes 2 □ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ CAVCUNDMA Breant 2 No 3 Probably 4 Unknown 1 🗌 Yes , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Yo 24a. Was an autops, performed: 254No certificate ! Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D351UZ 16,2011

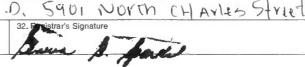
101

State Registrar 31. Date filed (Month, Day, Year)
MAY 1 7 2011

Don

HILLERY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/200

Baltimore Marylans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Joanne W. Hagin Physician/ Month May 15. 2011 9:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5529 Mattfeldt Avenue N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Hours (Month, Day, April 15 Country) 213-32-2366 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director N/A YY Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5529 Mattfeldt Avenue 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed ₩ Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Morris Musgrove Bradford Elizabeth Shanahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M. Hagin, JR. (Son) 1621 Northbend Rd. Jarrettsville. MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 5/18/11 Timonium, MD re of Funeral Servive IV ense 22. Name and Address of Facility urgee—Henss—Seitz Funeral Home 3631 Falls Road Balto, MD 2121 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onser and Death calons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final and Death Physician/ metastatio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to ror as a consequence of if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s after death.

s all Director: After this certificate hared in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Dath Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11^{Day} May Physician/ 20**1**1 0300 Joseph N. Harcombe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Westminster Carroll Hospital Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours 0972571939 71 South Africa 408-78-1990 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Woodbine Md. Carrol1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Funeral or items 23a USA 21797 933 Hoods Mill Rd. death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Minister Seventh Day 4YRS (1-4 or 5+) Elementary/Seconday (0-12) Minister Adventist Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Joseph D. Harcombe Thora Haydakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Hoods Mill Rd. Woodbine, Md. 21797. Cynthia Ann Harcombe(Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All County Cremation 05/13/2011 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Md. Signature of Fale al Service Lic 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VEUY 2 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗌 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural work' 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31, Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 4, Physician/ Arthur Dorothy Harrison 2011 3:40 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months July 31, 1929 Georgia 578-36-4869 **Director** 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Potomac 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 11116 Hunt Club Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last မ Arthur Henry Cleveland Jessie Brownlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11116 Hunt Club Drive, Potomac, Maryland 20854 Thea Marie Dillon/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of unk Date 20c. Location - City or Town, State cemetery, crematory or other place Arlington National Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensy 0 M01498 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ day disease or condition Respiratory Acidosis Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-trans attending physician and Due to (or as a consequence of) Physician/Medical Box 68760 cate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 0 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease 2 No 3 Probably 4x Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy After this certificate has perform Yes 2 K No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ၉ 1 🗌 Yes 2 🔀 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 🔀 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) May 5, 2011 D006117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Eric Park, M.D. 31. Date filed (Month, Day, Year) 62. Registrar's Signature State Registrar

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		•	1 - State Registrar	,	Cer	tificate of L	Death	,	Reg. No.		
	Physicia	m/	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month		Year	3. Time of Death
- 1	Medic	cal		ETTLEMAN				MAY		2011_	11:30P M
Stan of	Examin	er	4a. Facility Name (if not institution, g GILCHRIST HOSPI	·			r Location of Death WSON	1	4c. County		
	Funeral		5. Social Security Number 6	. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th		olace (State or Foreign
	Director		215-56-6069 Usual Residence of Decedent	1 X M 2 □ F 4	5 Yrs.	Wionthis Days	Tiodis Ithin:	05/18/	71965	- Court	MD MD
	and show dat	ē	10a. State 10b. County		c. City, Town or Loc	cation				1	0d. Inside City Limits
	Maryi 28a-f otifie	Director		TIMORE	В	ALTIMORE					1 🗆 Yes 2 💢 No
	ith the 3a or t be n	la D	10e. Street and Number	MC COURT		10f. Zip Code			10g. Citizen of V		itry?
	ems 2	Funeral	10 GARRISON FAR	12. Was Decedent Ever i	in U.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race	e - Americ	an Indian.
36	ifter de ", or it amine	by	1 Never Married 2 X Marrie	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		f Yes, specify Cuba	Specify:	Rican, etc.)		k, White,	
21215-0036	ours a atural cal Ex	Completed	3 Widowed 4 Divorced 15. Decedent	Year or Dates.		lent's Usual Occup			Specify:		ITE
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21	d with lygien her th	Be Co		5 +	PR	ESIDENT			GALVANIZ		COMPANY
and	id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho atic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Las	HETTLEMAN	i		18. Mother's Nan		GOLBORO	•	
Maryland	should and Me is marl	į	MICHAEL 19a. Informant's Name/Relationship		7	g Address (Street	and Number or Rui				Code)
Σ,	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		JULIE HETTLEMA	N/WIFE	10 G	ARRISON	FARMS COL	JRT , BA	LTIMORE,	, MD	21208
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once,		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐ Removal from State	0b. Place of Dispos Δ Demeters		ďγ	Date	20c. Location -	-	
Hir	artmer ortant injury	- 5	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lic		ARTINGTO	AMUNO C	05/15 ss of Facility SOL	5/2011	BALTIMO)RE,	MD
Ba	permit. Departr Importa any inju		> Lieth Mr.	Cutton			TERSTOWN				MD 21208
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	emplications that caused the yone cause on each line.	death. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician/ Medical	0 1	Immediate Cause (Final disease or condition resulting in death)	a. HoDGKin	J Lynn	Homa					Onset and Death
(Mayor)	Examiner		resulting in death)	Due to (or as a cor	nsequence of):						- (
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):						
	cuted .nd transit	Examiner	Cause (Disease or linjury that initiated events	с						\perp	
	death certificate be executed the attending physician and ed for use as the burial-transit		resulting in death) Last	Due to (or as a cor	isequence of):						
8760	tificate t ng phys as the l	Medical		d						<u></u>	
x 68	attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy Fetal death 3	Ectopic pregnance	ov.		23d. Dat	te of delive	ery
Вох	e death the att	Physician.	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)			Moi	nth	Day Year
P.O.	es that the dee signed by the a I be detached		Part II. Other significant conditions	s contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contr	ibute to th	ne cause of death?
ls, I	uires t n sign uld be	ed by						1 🗆	Yes 2 No	3 🗆 Prol	bably 4 🗆 Unknow
corc	The law requires ate has been sign page 2 should be	Completed						24a. Was auto		Vere autor	psy findings available mpletion of cause of
Re	The la							perfo	ormed?	death?	
ital	Physician: The this certificate ral director, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	ace of Death (Chec		•		1.
of V	g Phy er this neral d	te: To	27. Manner of Death	1 □ Inpatient 28a. Date of injury (Month, Day, Yea	2 ER/Outpatien	28c. Injun	y at		dence 6 🛭 Othe		HERPICE
on	Attending or death. ector: After by the fune	ificat	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ion	ar) injury	M 1 🗆	Yes 2 No				
Division of Vital Records,	or Att	Certificate:	4 Homicide determine		At home, farm, stre ecify)	et, factory, office		28f. Location (S City or Tov	Street and Numbe vn, State)	r or Rural	Route Number,
	spital		29a. Certifier Certifying P	hysician: To the best of my k	nowledge, death o	ccured at the time	, date and place, a	nd due to the ca	use(s) and manne	er as state	d.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exa	miner: On the basis of examinurse Practioner: To the best	nation and/or investi	igation, in my opinic	on, death occurred a	at the time, date a	and place, and due	to the cau	use(s) and manner stat
	No the To the come		29b. Signature and title of certifier			29c. License	e number		29d. Date signed	l (Month, L	Day, Year)
			- your	(200	(1)		8303		MITY 1	3 7	2011
,			30. Name and address of person wh				J-1 C -	- 17	1002	100	2

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Eberthardt Inen 1005 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL ST AGNES BALTIMORG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Months Min. April 23, Year) 1934 Country) Indonesia Hours 212-42-6944 77 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 905 Southridge Rd. USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 🛣 Married þ ☐ Yes 2 K No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Garret Μ. Inen Albertina Inen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie M. Inen (Wife) 905 Southridge Rd., Catonsvi 1e, MD 21228 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 5/14/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Severe Medical resulting in death) Due to (or as a consequence of): Examiner YEARS cromavy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Stage Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Year ned by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Diabetes Records, Hypertension, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 P23 49 MAY ss of person who completed cause of death (Item 23a) (Type, Print) 900 S CATON AVE BALTIMORE MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Mav ^{Day} 2011 Beatrice Harvey Iglehart 5:29 PM 13. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Days Sept 7, Months Year) 1927 Washington, DC Director 577-36-1190 83 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Ves 2 X No Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ital Hygiene. 3d other than "natural", or items 23a event, the Medical Examiner must t U.S.A. 3844 Jennings Chapel Road 21797 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 2 1 Never Married 2 X Married ☐ Yes 2 🔀 No within 72 hours after 1 ☐ Yes 2X No Specify. Specify: White Yes. Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Manager Public School System marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental F 2 pe Edna Augusta Ray Edgar Charles Harvey and 2 should be Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3500 Geyton Downs Court, Richmond, Virginia 23233 Julia I. Dunn / daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Union Cemetery May 17, 11 Burtonsville, MD 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses any M00773 Laurel Maryland 20707-4389 313 Talbott Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heatyfailure. List only one cause on each line.

Immediate Cause Final disease or condition

B. Vecs. + Concernia Approximate Interval Between Onset and Death Physician/ Yeurs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 Yes 2. No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆

Division 1/2

Baltimore, Maryland 21215-0036

Box

P.O.

Records,

of Vital

State Registrar

29b. Signature and title of certifier

ALUX

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUZ

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Olyey- Levitorsulle ful

29d. Date signed (Month, Day, Year)

13,2011

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P3CAM AMES 12 Medical Facility Name (if not institution, give street and number) 4b: Sity, Town, or Location of Death 4c. County of Death Examiner 05 DICE anda 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 1 M 2 D F Days Months Hours Min Country) 68 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No I and 2 should be filed within recommend the and Mental Hygiene.
I Health and Mental Hygiene.
I item 27 is marked other than "natural", or items 23a or item 27 is marked other than "matural", or items 25a or item 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 23a or items 27 is marked other than "matural", or items 27 is marked other 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? If Yes, specify Cuban Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT_use retired) Seconday (0-12) Elementary/S College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ injury or other traumatic ames Informant's Name/Relationship (Type, Ffrint) 19b. Mailing Address (Street and Number or Rural Route Number, Cit of Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau MD 21207 00 HIMOre lames 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - Gity or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 20-2011 Signature of Funeral Service Licens 22. Name and Address of Facility C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ a Medical Due to (or as a cons a uence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Year 5 Other (specify) Month Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 4 Unknown Records, 1 Yes 2 No 3 Probably Completed should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate has page 2 s autopsy Hospital or Attending Physician: The Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie person who completed cause of death (item 2 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 12, 2011 Emmaline W. Jankowski 9:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care, N/A Irvington **Baltimore** If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea Sept. 22, 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Baltimore. Sept. "1915 Director 216-03-5697 95 Usual Residence of Decedent shov 10a. State 10d. Inside City Limits 10c. City. Town or Location event, the Medical Examiner must be notified at Director Timonium 28a-f 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral with 1 23a 12030 Tralee Road Unit 205 21093 USA May items ; Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married Completed by **Maryland 21215-0036** 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White "natural", 3 X Widowed 4 Divorced Jankowski Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor at Westinghouse Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Τ. Watts Margaret Flynn injury or other traumatic 3 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 12030 Tralee Road Unit 205 Timonium, MD 21093 Patricia Mitchell/Daughter Emmaline Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadowridge Memorial Park Cemetery 1 X Burial 2 Cremation 3 Removal from State 16 4 Donation 5 Other (Specify) 2011 Elkridge, MD 22. Name and Address of Facility emmon funeral Home of Dulaney 10 W. Padonia Road Timonium, Signature of 5 any J. Flagle chae1 1. Friter the dis , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician DEMENTI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury and -trans that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death the 9 Unknown 9 Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an aw Jas autopsy perform Hospital or Attending Physician: The certificate 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🖂 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 006586 MD 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Awan, M.D. 2717 Hammonds Ferry Road Halethorpe, MD 21227 Hasan A.

State

Registrar

31. Date filed (Month, Day, Year)

1

7 2011

32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JOHNSON **Physician** 2011 HVID /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 74 July 31 MD 577-48-5594 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 1 Yes 2 No Director MD Carro11 Westminster 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number death with 931 Humbert School House Road 21158 **USA** Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. Specify: White \$ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Salesman Insurance 12 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be . Pages 1 and 2 should be iment of Health and Menta tant: If item 27 is marked Franklin U. Johnson Edna May Doffmyer မ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ms. M. Lynn Johnson (Daughter) 8 Willow Court, Hanover, PA 17331 permit. Pages 1 and Department of Health Important: If item 2: any injury or other tonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 5/18/2011 Sykesville, MD Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 - Ectopic pregnancy Live birth Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) detached f 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 000 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pade 2 🗆 No 1 Tes 1 Tyes 2 or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2X No Impatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Deal 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation s after dec. 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 NISHA. nth, Day, Year) 31. Date filed (Month, 32 State Registrar

DHMH 17 Rev 1/2001

				Please Type or Print in E				-		15700
				for State of Maryland				al Hygie	ne	15/00
				Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Deat		Reg.	No.	3. Time of Death
		Physicia Medic		Maryann Stella Janis	ki			onth ay 15	Day 2011	6:10 A M
		Examin		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Helalth		4b. City, Town, or Locat Bel Ai	tion of Death		4c. County of Deat Harford	
		Funeral Director		5. Social Security Number $216-36-8352$ 6. Sex $1 \square$ M 2 \square F 7 . Age (In yrs. later) 7. Age $2 \square$ 7. Age (In yrs. later) 7. Age $2 \square$ 7. Age (In yrs. later) 7. Age $2 \square$ 7. Age (In yrs. later) 1. Age $2 \square$ 7. Age (In yrs. later) 1. Age $2 \square$ 7. Age (In yrs. later) 1. Age $2 \square$ 7. Age (In yrs. later) 1. Age $2 \square$ 8. Age (In yrs. later) 1. Age $2 \square$ 8. Age (In yrs. later) 1. Age $2 \square$ 9. Ag	st birthday) Yrs.	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8. Da urs Min. (M 1 2	ate of Birth fonth, Day, Yea	9. Bird 9. 3 7	hplace (State or Foreign untry) MD
ı		and show	tor		, Town or Loc	cation		- '		10d. Inside City Limits
		the Maryland or 28a-f show e notified at	Funeral Director	MD Harford 10e. Street and Number		10f. Zip Code	Bel		. Citizen of What Co	1 Yes 2 XNo
		th with the ms 23a of must be	nera	900-A Martell Court		2101			US	
0100	9036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If firem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	쥰	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4X Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates.		Vas Decedent of Hispanio f Yes, specify Cuban, Mex □ Yes 2 🏋 No Spe		es or No- etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
	215-(in 72 hou e. ian "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	lent's Usual Occupation kind of work done during i O NOT use retired)	most of working	168	b. Kind of Business	Industry
110	121	d with lygien ther th nt, the	Be Co	1 2 17. Father's Name (First, Middle, Last)			Clerk		Retai	.1
120	ylanc	ld be file Mental H arked of atic ever	To E	Alexander Janiski		18. N	Nother's Name (First, esse Je	, Middle, Maid anett	e Kowals	ki
5/15/201	Mar	d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Linda A. Krug / Daughter	19b. Mailin 3685	ng Address (Street and Nu 5 Double R	imber or Rural Route lock Lan	e Number, Cit, e , Ba.	y or Town, State, Zig Ltimore,	MD
5	Baltimore, Maryland 21215-0036	age 1 an ent of He nt: If iten ny or oth				sition (Name of natory or other place)	Date 5/18/20	- 1	c. Location - City or	
	Baltii	permit, P Departm Importal any injur		21. Signature of Funeral Service Licensee Dorota Marsha		Name and Address of Family Name PO Box	acility		· ·	
	п			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente				re, MD	21203 Approximate Interval Between
19	,	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	Red	petany 1	toilur			Onset and Death
38		Examiner	ıer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	ence of):	Heart	taline			
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2		ij jaj e		d.	5) Ce (1).					
	6876	eath certificate be attending physicial for use as the bur	/Mec	IF FEMALE: 23c, If yes, outcome of pregnan	ncv.					
maryann	Division of Vital Records, P.O. Box 68760 Hospital of Attending Physician: The law requires that the clear cartificate has	y the attenched for us	Physician/Medical	23b. Was decedent pregnant in the past 12 morths? 1	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
10	s, P.O	been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resu	ilting in the u	nderlying cause given in F	Part I.		co use contribute to	the cause of death?
ar	Sords	has been de 2 should	Completed				2	4a. Was an autopsy	24b. Were au	opsy findings available completion of cause of
3	I Rec	certificate ha		25. Was case referred to medical		26 Place of	Death (Check only o	performed Yes 2	death?	2 No
-	Vita	this certifical	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ME	R/Outpatien	Lother			e 6 Other (Speci	fv)
SK	n of	th. After th funeral	cate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 □ Yes	28d. D		njury occurred	
aniski	Visio	or the most after death. To the Funeral Director: After completed filled in by the funeral process.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)			28f. Lc	ocation (Street ty or Town, St	t and Number or Rui tate)	al Route Number,
Ja	Osnital	hours a	Medical (29a. Certifier 1	edge, death c	occured at the time, date a	and place, and due to	to the cause(s	s) and manner as sta	ted.
	d d	thin 24 the F omplete	Me	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier			date and place, and	due to the cau	ise(s) and manner as	stated.
-	٩	5 ½ 6 8		Dentino 20			6487	1.0	Date signed (Month	2011
4)			30. Name and address of person who completed cause of death (Item : Steven M. Bentman MD :		rint) Poer Cinesc	DECKOT	CHE	Rol Arr	mp 21014
ن ن		Stat Registra		31. Date filed (Month, Day Year) 32. Registar's Signit	reke!	rw UKS		21 IV	12/1/11	
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					ORIGIN	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** a mes 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give breet and number) Examiner 4zerne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 219-38-1 □ M 2 1 F Months Days Hours 7260 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code zerne Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) atere 18. Mother's Name (First, Middle, Maiden Şurname) 17. Father's Name (First, Middle, Last) , Be Nilham Cella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is any Injury or other trau once. 710 burn Are ma, 2 eto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5-19-2011 ansdrine 4 □ Dghation 5 □ Other (Specify) 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of tring, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line.

Immedi he Cause final disease or conditt in resulting in death) W. Frank xeltoing, 21229 Approximate Interval Between Onset and Death **Physician** /Medical Examiner ance Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 2 No P.0. 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ►No 24a. Was an autopsy performe Vital 2 No 1 ☐ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 1000 E. Gager Street, Baltimore Michael MO.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

122 Registrar's Signature

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oshua William Kneas	State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	-	Certi	ificate of	Death			Reg. No	L U I I	10/10
Physicia	an/	1. Decedent's Name (First, Middle,Las	t)					Date of D Month	Day	Year	3. Time of Death
Vedical Exami	ner			KNEAS				May 10	, 2011		1238 hrs
		4a. Facility Name (if not institution, giv 3867 Parrot Drive	e street and number)		41	b. City, Town, Ellicott Cit		of Death		c. County of Death	
Europol		5. Social Security Number 6. Se	ex 7. Age	e (In yrs, las	t birthday)	If Under 1 Y	•	er 24Hrs. 8. Date of		//DD/YYYY) 9. Birt	hplace (State or
Funeral Director							ays Hours	Min		Foreig	n
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.	Ļ	MD HOW	ARD		ELLIC	OTT C	ITY				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f, Zip Code	•		10g. Ci	itizen of What Cour	ntry?
r death with the Maryland , or items 23s or 28s-f sho : must be notified at once	盲	3867 PARROT I	DRIVE			2	1042			U.S.A	•
with with be no	<u>a</u>	11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of I	Hispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Americ	can Indian, Black,
death or ite	Funeral	1 X Never Married 2 Married	1 Yes 2	No							
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	ò		If Yes, Give Year or Dates:			Yes 2XI			T ₄ Ch		HITE
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examines	B	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5			st of working I		kind of work done use retired)	160.	Kind of Business/li	ndustry
36 hin 72 e. than "	be	Elementary/Secondary (0-12)	4	,··)	SOFT	WARE 1	ENGTN	EER		COMPU	TER
5-00 lled with Hygien the Me	Completed	17. Father's Name (First, Middle, Last)		1				's Name (First, Midd	e, Maide		
	Be (WILLIAM KN	EAS				ВО	NNIE W	IARD		
2121 ould be fi d Mental s marked ifc event,		19a, Informant's Name/Relationship (T	ype, Print)		the state of the s			nber or Rural Route I			
MD d 2 sho lith and n 27 is numati		WILLIAM KNEAS/	FATHER								MD 21042
imore, MD 2 Pages 1 and 2 shou nent of Health and h iant: If item 27 is n or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Sta		ace of Disposit ematory or othe		cemetery,	Date	20c	. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		4 Donation 5 Other Specify		BAY				5/14/11			E, MARYLANI
Salt ermit, epartr nport		21. Signature of Funeral Service Licer	isee	-8	22. Na L I	ame and Addre	ess of Facility	ER INC.	FUN	ERAL HO	ME
	_	23a. Part I. Enter the disease, or comp	ligations that assessed	the death F	l 19	01 EA	STERN	AVENUE,	BAL	TIMORE,	MD 21231 Approximate Interval
Physician		failure. List only one cause on ea	ach line.	tile deatil. L	JO HOL EIREI UN	e mode or dyn	ig, such as c	ardiac or respiratory	arrost, si	ioux, or riour	Between Onset and Death
Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Asphyxia Due to (or as a conse	equence of):							
		Sequentially list conditions, b.	200 10 (0) 40 4 00,100	,440,100 01).							
	횰		Due to (or as a conse	equence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
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9 .00 .00	Medical	UNPENDED	AMENDED								
68760, certificate be nding physicise as the burit	Š	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	ne of pregna	incy				2	3d. Date of delivery	
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Box e death contract the attenued for us	Physician	1 Yes 2 No 9 Unknown			□ Oth	er (Specify)			1		
. 2 . 2 .		Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying caus	e given in Pa				the cause of death?
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B	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗌 E	R/Outpatient	3 DOA	Other ₄	Nursing Home 5	Resid	dence 6 🗸 Other	Scene
on of Vital ending Physician: path. or: After this certif the funeral director,	٦	27. Manner of Death	28a. Date of Inju (Month, Day, Y May 10, 2011	ry 2 ear)	28b. Time of In 1220 hrs	· · _	njury at Work	. Subject n		njury occurred helium filled pla	astic bag over
	atie	1 Natural 5 Pending 2 Accident Investigati	ion				Yes 2 ✓	head			
Division ral or Attendi rs after death. al Director: /	Certification:	3 ✓ Suicide 6 Could not determine				t, factory, offic	e building, et			and Number or Ru Ellicott City, MD	ral Route Number, City
Divisio Hospital or Atten 24 hours after death Funeral Directors		4 Homicide	(10)		12	0.7.62.1				ur consessor	
Division of To the Bospital or Attending Ph within 24 hours after death. To the Funeral Director: After temperal pirector: After temperal pirector or prompletely filled in by the funeral	<u>is</u>	(Check only one) 2 Medical Examine	ian: To the best of my r:On the basis of exam	y knowledge mination ang	death occurr	ed at the time, on, in my opin	ion, death oc	ace, and due to the c courred at the time, d	ause(s) a ate and p	and manner as state place, and due to the	e cause(s)
To 1	Medical	29b. Signature and title of certifier	and manner stated.	/			ense number			I. Date signed (Moi	
	116	Unla	~		00	0.0	C.M.E.		Ma	ay 11, 2011	
4		30. Name and address of person who	completed cause of d	eath (Item 2	, 1/						
V			Assistant Medic			V. Baltimo	re Street,	Baltimore, MD	21223		
St	tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	21						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day May Month 2ďľ1 Emma Ρ. Kuhn 9 12:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🛛 F Hours Year 1924 July 24 407-30-0753 86 Director Kentucky Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 X Yes 2 □ No Montgomery Rockville 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9501 Veirs Drive, Unit 1 20850 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 🕅 Widowed 4 🗆 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 3 $\frac{1}{2}$ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orie Payne Juanita Root I and 2 should by Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David P. Kuhn 650 Garfield Avenue, Lake Bluff, Illinois 60044 injury or other Baltimore, 20a. Method of Disposition

1 💆 Burial 2 🗌 Cremation 3 🗍 Removal from State Date 15, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2011 Rockville, Maryland 21. Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Juzalette 1 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner BILATERAL ELLULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dualto for as a consistence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical イダルトピーク えし Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by POLYCYTHEMIA VERA 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform HYPERTENSION 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Mamar Huby Med DOO 62562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER DRIVE ROCKVILLE MARYLAND MADHAVI HUBBLY MD 9901 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

2011

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MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 15 2Ö1 1 10:55 AM Lois Arlene Kirby Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days 1 □ M 2 🗶 F Hours Months Maryland 220-32-5731 Director 74 February 1, Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Silver Spring ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 321 University Boulevard 20901 West United States an "natural", or items Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Lerner Corporation 12 Receptionist Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked or ည Oscar Kirby Margaret Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce, Bob Johnston/Friend 155 Chesapeake Mobile Court, Hanover, Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park May 19, 2011 Rockville, Maryland permit. Signature Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda. Bethesda-Chevy Maryland 20814 Chase, Inc. M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Metastatic Rectal Cancer disease or condition Medica! resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? detached for Month the 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} X \square$ Other (Specify) Hospiceည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide
4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 May 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Bindu C.

Joseph,

32. Registrar's

ack

M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Thomas King Month Mason Physician/ 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Street Ocean Colony 47th DORE g. Birthplace (State or Foreign Birthpic Country) NJ 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Min. 229-09-4152 09/10/ 1 □**X**M 2 □ F 91 1919 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director ocean City MD Worcester 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 19 Ocean Colony 47th Street 21842 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Xes 2 No WW þ 1 Never Married 2 Married IISpecify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 XWidowed 4 Divorced Year or Dates. Army 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Retail Salesman and Mental Hygier is marked other i 27 is marked other r traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Hamilton 17. Father's Name (First, Middle, Last) James Nelson King 2 Page 1 and 2 should be 1 ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19520 Olney Mill Rd., Olney, MD 20832 homes /Son Thomas M. King, Jr. permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final journey crem 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 5/18/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland
PO BO 14 al Service Licensee Derona Marshall d Cremation Services 1413, Baltimore, MD Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ montes disease or condition ceno Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Dav in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe page 2 Yes 2 No 1 Yes 2 No this certificate director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO No 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After **☒** Natural 5 Pending 1 Yes 2 No n 24 hours area one ne Funeral Director: A Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO; 5302 CHINABERRY DR. SALISBURY GORIO M. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2011 Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th g915 5-26-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1938 Month Year RBG Physician/ 2011 OBERT Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, 01/25/ Birthplace (State or Foreign Country) 5. Social Security Nu**01424** 552-88-1952 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 ☑ M 2 □ F Months Hours 1952 59 Director 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director Laurel Prince George MD 1 X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 200 Fort Meade Road #5 Funeral or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates Navy Black, White, etc. Specify: White 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes XX No Specify: "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Entertainment Salesman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Palmer Delma မ Denver Kerby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14910 Running Horse Pl., Bowie, MD 20715 19a. Informant's Name/Relationship (Type, Print) Carole Rehm/Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1
Burial 2
Cremation 3
Removal from State 5/14/2011 Woodbine, MD Final journey crem 4 Donation 5 Other (Specify) Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Funeral Service License Dorota Marshal. Ve 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions ne Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1. Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 4 W Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE 41 32. Registrar' Signatu State Registrar

11-03670 Jihyoung Lim

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inyoung Lim		State of Maryland / Department of Hea 1- For State Registrar Certificate of Dea		_	201; g. No.	1571
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month	n Day Year	3. Time of Death 1600 hrs
neulcai Examii	iei	0.11000.19	Town, or Location of Death	May 15, 20	11 4c. County of Death	
		Shady Grove Adventist Hospital Rock			Montgomery	
Funeral Director		220-79-8391 1×M 20F 30Yrs. Mont	der 1 Year If Under 24Hrs. ths Days Hours Min.	8. Date of Birth	1980 Foreig	
sus.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits
Aaryland 28a-f show	ē	MD Montgomery Gaithers	sburg			1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	Director	10e. Street and Number 121 Timber Drock LN 304	p Code	10	g. Citizen of What Cour	AVEC
n with the ms 23a be not		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deced	lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto I		14. Race - Ameri White, etc.	can Indian, Black,
er death	Funeral	1 Yes 2 No	2 ⊠ No specify:	Ricari, etc.)	Specify: A	Sign .
ours aft atural" xamine	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua	I Occupation (Give kind of w		16b. Kind of Business/li	ndustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Stylist	<u>.</u>	Cosemo	tologist
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	17. Father's Name (First, Middle, Last) MON Sup Lim	18.Mother's Name	(First, Middle, M	The same of the sa	19
21; hould b and Men is mar	P		s (Street and Number or R	4 62		
and 2 sho fealth and traumati	ŀ	20a. Method of Disposition 20b. Place of Disposition (Na		N #300 Date,	4, Vaither 20c. Location - City or	SOUIG, MD Town, State
MOCC Pages 1 ent of F		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	" 5/1	18/2011	Hanove	u, MD
Baltimore, permit. Pages I a Department of He Important: If ite			d Address of Facility	wese	Funera	Home
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	of dying, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Asphyxia				Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b. Hanging				
	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
1 B = 1	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
an and	ledical	d. UNPENDED AMENDED				
760, cate be exe		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68760, death certificate be attending physic of for use as the burner of for use as the burn	cian	past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe		ncy	Month D	ay Year
BO)	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown		Loo- Bida-h	acco use contribute to t	he arrive of death?
i, P.O.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying	j cause given in Part I.		2 ✓ No 3 Prob	
of Vital Records, ig Physician: The law require the this certificate has been sineral director, page 2 should be	Completed			24a. Was ar		opsy findings available
Reco	Ĕ			perform 1 Yes 2	<u>ed</u> ? death?	s 2 No
ital Redicion: The scertificate irector, page	8	examiner? [Hospital: 4] Investigat 2 4 FR (0) Investigat 2 5	26.Place of Death (Check of DOA Other, Nursing		esidence 6 Other	
ing Phy After thi	은	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month Day Year)	28c. Injury at Work?	28d. Describe ho	w injury occurred	
Division ra or Attendi rs after death. In Director: A	Satio	2 Accident Investigation May 15, 2011 1515 hrs	1 Yes 2 V No	Subject hang		
Divis	Certification:	Suicide 6 Could not be determined Could not be determined Could not be determined (Specify) Park/Recreation Area		or Town, Sta	reet and Number or Rur ite) , Redland , MD	al Route Number, City
	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m				
To with To com	ĕ	and manner stated. 29b. Signature and title of certifier 29	c. License number		29d. Date signed (Mor.	th, Day, Year)
5		Afle Brasselfe de	O.C.M.E.		May 16, 2011	
9		 Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltir 	more Street, Baltimor	e, MD 21223		
Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signature				
registi	للت	MILLE LOTT COLORED P. MARIE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 Medical 4a. Facility Name (if not institution, give street **Examiner** City, Town, or Location of Death 4c. County of Death Monkton BALTIMORE 000 Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min BALTIMORE, Director 23a or 28a-f show 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral or items 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian ☐ Yes 2 No If Yes, Give Year or Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su RobiNSON ပ should be INSOR 9a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number onald Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 🗋 Donation 5 🗌 Other (Specify) permit. 21. Signature of Funeral Service Licensee or complicate 23a. Part 1. Enter the disease ns that caused the d eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 fronths? 3 Ectopic pregnancy for Dav 5 Other (specify) 1 Yes 2 page 2 should be detached of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2

No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner_of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Could not be Accident To the Funeral Director Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check dical Examiner tifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 3902 2011 17

Registrar

State

ompleted cause of death (Item 23a) (Type, Print) E,MD, 1447 York Rd,

& t-, mac, mb

2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 7:30 AM Leviton May Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Adelphi 2007 Pelden Road 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Washington, (Month, Day, 02/09/ 1 🔀 M 2 🗆 F Director 80 578-38-7470 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 No Adelphi Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A 20783 2007 Peldon Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Levitoff Leviton Mildred 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2007 Pelden Road, Adelphi, MD 20783 Susan Leviton / Wi<u>fe</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 05/16/2011 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Averal Service Livense 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final CANCER Phylician/ ESOPHAGE AL YEARS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month in the past 12 months? Day Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ARTERY DISGASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?
1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number M.D. D42452 MAY 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR CHITCA RAJAGOPAL PHILIP DRIVE OLNEY, # 327, 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Mcelland Le		r S	tate of Ma	ryland				and	Mental H	lygiene		001	1 1 1	
		Registrar 1. Decedent's Name (First, Mide	do Last\		Cer	tificate of	Death			2. Date of Dea	Reg. No	o. /	3. Time of Death	
Physicia Medical Examin		Paul McClel		azer						Month May 13, 2	Day	Year	2123 hrs	
		4a. Facility Name (if not instituti					4b. City, Town,	or Lo	cation of Deat			tc. County of Dea	th	
		141 Teal Drive Ocea	n Pines				Berlin					Worcester		
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. Ia	ast birthday)	If Under 1 Y	ear ays	If Under 24Hr Hours Mir	$\overline{}$		N/DD/YYYY) 9. B Fore	ign	
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any		Usual Residence of Decedent 10a. State 10b. County		_	10c. City.	Town or Locat	ion					-	10d. Inside City Limits	
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Maryland 28a-f show	Director	10e. Street and Number					10f. Zip Code	е	_		10g. C	itizen of What Co	untry?	
the M	<u></u>	11405 Smiloff	Road				21162				Ţ	J.S.A.		
r death with the Maryland or items 23a or 28a-f sho must be notified at once	era	11. Marital Status	A	s Decedent					anic Origin? (S Mexican, Puerto	pecify Yes or N	No- 14. Race - American Indian, Black, White, etc.			
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5-0036 iled within 7 Hygiene. I other than the Medica		17. Father's Name (First, Middle	, Last)					18	3.Mother's Nam	e (First, Middle,	Maide	n Surname)		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at sonce.	٤	Catherine Tho			tr.					White 1			21162	
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Baltimore, bernit. Pages I ar Department of He. Important: If it		1 Burial 2 X Crematic		val from St	ale	rematory or ot	nerplace) Cremati	on	Sor	5/17/11	٦	len Burr	ie. MD	
Baltin permit. P Departme Importar	ł	4 Donation 5 Other 5 21. Signature of Funeral Service			ACI	22 N	Jame and Addr	'ASS 0	f Facility			Ten Dan		
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Physician		23a. Part I. Enter the disease, of failure. List only one cause	r complications to on each line.	that caused	the death.	Do not enter t	he mode of dyi	ng, sı	uch as cardiac	or respiratory ar	rest, s	hock, or heart	Approximate Interval Between Onset and	
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Box 6876; death certificate the attending phy defor use as the b	ia.	past 12 months?	, L	Live birth Pregnant at	time of de	oth -	tal death her (Specify)	3	Tectobic bregit	aricy		MOHUT	Day real	
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n of Vital Records, P.O ling Physician: The law requires that t After this certificate has been signed by finneral director, page 2 should be detac	위	1 Yes 2 No 27. Manner of Death	28a	Date of Init	ırv	28b. Time of I			at Work?			njury occurred		
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To th withi To th	Wed	one) 2 ✓ Medical Ex 29b. Signature and title of certif	and man	ner stated.			29c. Lice					d. Date signed (M		
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	}	30. Name and address of person	n who complete	d cause of	death (Item	23a)							<u></u>	
0*1			ssistant Med				timore Stre	et, E	Baltimore, M	1D 21223				
Sta	-	31. Date filed (Month, Day, Year		Registra	ar's Signatu	ire	1.1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month :13 PM Frieda Clara Link . Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie MD Anne Arundel Baltimore Washington Med. Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours July 6, 1911 213-34-9594 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits within 72 hours after death with the Maryland Director r 28a-f sl notified MD Anne Arundel Linthicum Heights 1 Yes 24 No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code "natural", or items 23a o 21090 Funeral 111 W. Maple Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 XNO 1 Yes Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 0 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Waldman Clara Serbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Link / Son 111 W. Maple Road Linthicum Heights, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 14 2011 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Inset and Death Phy i i n/ Vneumunia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Veal Pregnant at time of death 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lymphory to eullemin 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25861 13 2011 Mau

State Registrar Maiden Choice Lane Suite 101 Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ b Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 D F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Hours Min 0977271929 Yrs. 076-24-4860 81 NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7418 KATHYDALE ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces 2, 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎗 No Specify 3 Widowed 4 X Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) OPTOMETRIST OPTOMETRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH LESSER ETHEL BILUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO LEE LESSER ROXIN/NIECE 3411 OLD FOREST ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UNITED HEBREW CEM. 05/13/2011 STATEN ISLAND, NY 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Tes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of death? autops perforn Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: No 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Ceath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident Pending 1 🗌 Yes 2 🗌 No Investigation the 3 Suicide Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowle eath occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ldrou

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 9:27 John Francis McBride May р Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Country)
NY 1935 Feb. Director 070-28-2756 76 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗆 Yes 2 😾 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country's "natural", or items 23a o Funeral 12200 Burncourt Road, Unit 102 21093 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No þ 1 Never Married 2 🕅 Married 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 Widowed 4 Divorced 541-571 Year or Dates. the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Insurance <u>HR Manager</u> is marked other Be Baltimore, Maryland 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 James McBride Catherine Keaveney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Mrs. Susan M. McBride/wife 12200 Burncourt Rd. #102, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 5/17/11 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Funeral Service Lisens Q. Michael O W. Padonia Rd., Timonium, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Phytician END STAGE RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Year 5 Other (specify) Pregnant at time of death JOHN MCBRIDE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 ☐ No After this certificate Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\text{Yes} \quad 2 \(\text{No} \) 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 X Natural of Funeral Director: Aft Director: Aft Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b, Signature and litle of cer 29c. License number 29d. Date signed (Month, Day, Year) 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE JONES, Registrar's Si State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death >03 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** hayer more If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** (In vrs. last birthday) Min 1 M 2 M Month, Day, **Director** 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1
Yes 2 □ No more ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc is marked other than "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Black Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 1300K erk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mide မ ٥ Dasie 19a. Informant's Name/Relationship (Type, Print) ral Route Number, City or 19b. Mailing Address (Street and Number permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau aulcon 4223 Voris law 20a. Method of Disposition 20b. Place of Disposition (Na 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign re f Funeral Service License 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final Ph sician/ on disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached t 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform the Funeral Director: After this certificate Inpleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Antural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 h To the Fun (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cortifier 30. Name and address of person no completed cause of death

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-13-2011 801 Dorothy Noll D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Hours Min 06-16-1921 89 Director 216-12-3541 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD Harford 1 Yes 2X No Forest Hill 10e. Street and Number 10f. Zin Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

Department of Health and Tis marked other than "natural", or items 23a or mortant injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be. Funeral 1941 Pleasantville Rd 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Grayson Sparks Elizabeth Danzeglock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Schafer (Daughter) 1941 Pleasantville Rd Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 05-18-2011 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility of BelAir Schimunek Funeral Home Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Recurrent Ph sician/ Aspiration Preumonia disease or condition MKNOW Medical resulting in death) Due to (or as a consequence of) Examiner Jostnaium nanoun fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami Denumbia MENUN attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy NOIL, porothy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

400

3

15

DOD

500 upper

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FISHER

31. Date filed (Month, Day, Year)

D0065421

May, 13, 2011

Chesapeake Drive, Bel Ar, Maryland 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month UBERT 1018 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death IMBR-CHESABAKE HARFER MODICAL - (BNIB) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1XIM2□F Country Maryland Months Hours Min JUIY 17 (ear) 1940 213-36-0111 Director 70 Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Bel Air 1 XYes 2 No Harford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21014 USA 402 Daniel Court death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Town and City College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Public Administrator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Naomi Virginia Nagle John Albert Northwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Daniel Court, Bel Air, Maryland 21014 Grace Ann Northwood / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/12/2011 Darlington, Maryland Darlington Cemetery Signature Funeral Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERKAGEMIA Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if at y leading to in recision cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ivision of War Records, 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably DUABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) tho completed cause of death (Item 23a) (Type, Print) UPPER CHOSSAGAHES DR 31. Date filed (Mo State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore County OWSOF CKERSGILL 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 219-01-4404 93 Nov. 02, 1917 Baltimore, MD. **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Maryland Baltimore County Towson 1 🗆 Yes 2 🏝 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21204 615 Chestnut Ave. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No Army 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Yes 2 No Arm If Yes, Give Year or Dates, W.W.II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed 3

M Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) **N/A** Elementary/Seconday (0-12) Mental Hygiene. 11 Wallpaper Hanger U.S. Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Snyder Aymar Emburg Oakley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pol Air Marvland 21014 Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) Mr. John Alexander Oakley (Son) 203 Regent Drive Bel Air, Maryland Tuesday, (Harford Councy, lay 17,2011 Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Futeral Oracel and Cremation Services, Inc. 1 Burial 2 Permation 3 Removal from State injury or May 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Leffrey L.Gir, Sr. OSS 22. Name and Address of Facility Funeral and Gremation Center, P.A. Lic.#M00677 Timonium, Maryland 2325 York Road 23a. Part 1 Eight the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final nset and Death Physician ACUTE MYOCARDIAL disease or condition INFARCTION MINUTER Medical resulting in death) **Examiner** ORONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISOAS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of death? IPIDEMI 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work Accident Investigation 1 Yes 2 | No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) who completed cause of death (Item 23a) (Type address of person Date filed (Month, Day, 32. Registrar's Signature Registrar

11-03561 Carroll Owens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carroll Owens		1- For State Registrar	Sta	te of Maryla		artment o e <i>rtificat</i> e o			Mental	Hygiene	Reg. No	201	1 15/2
Physici Medical Exam		Decedent's Name Carroll.		Last)						2. Date of D Month May 11,	Day	Year	3. Time of Death 2345 hrs
		4a. Facility Name (if Northwest H		give street and nu	imber)			own, or Lo	cation of De		4	c. County of D Baltimore (
Funeral Director		5. Social Security No. 220–86–6208		5. Sex 1 X M 2 F	7. Age (In yrs.	last birthday) 45 Yrs	Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of Min. 2-22-			Birthplace (State or preign Country) MD
any		Usual Residence of 10a. State 1	Decedent 0b. County		10c. City	y, Town or Locat	tion						10d. Inside City Limits
yland f show once	ţor	MD 10e. Street and Num	Baltim	ore		Owings Mi					10 0		1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once,	Director	9020 Amber		ay			10f. Zip	1117				tizen of What (JSA	Country?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-fahe ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married		ried Armed Fo	2 X No		es, specify	Cuban, N	fexican, Pue	(Specify Yes or I erto Rican, etc.)	No-	merican Indian, Black,	
ours afte ntural",	by	3 Widowed 15. Decedent's Edu		or Dates: y only highest grace		16a. Deceder		(Give kind		specify: African-American 16b. Kind of Business/Industry			
17215-0036 Id be filed within 72 hours after Alental Hygiene. narked other than "natural" event, the Medical Examine.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Division					nost of working life. DO NOT use retired) on of Corrections					tate of N	Maryland
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than	Be Co									ame (First, Middle		,	
Z = 4 = 5	Tol	19a. Informant's Nan	ne/Relationship					Jerry or Rural Route N			itate, Zip Code)		
2 2 9 5		Diane D. Ow	osition			Place of Dispos crematory or ot	Amber sition (Nam	Oaks V	lay, Ow tery,	ings MIIIs Date	20c.	21117 Location - City	y or Town, State
Baltimore, Permit. Pages 1 at Department of He Important: If ite	_	1 X Burial 2 Donation 5	Other Spec	cify:	om State K	ing Memor	ial Pa			21-2011		dlawn, N	
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Fund	eral Service Li	H. Wl	New					ne runera andallstow		-	of Baltimore Co.
Physician /Medical Examiner		23a. Part I. Enter the failure, List only Immediate Cause (F	one cause or inal disease		V								Approximate Interval Between Onset and Death
		or condition resulting		Due to (or as a b.	consequence	of):							
	fedical Examiner	if any, leading to imn cause. Enter Underl (Disease or injury that events resulting in de	nediate ying Cause at initiated	Due to (or as a c. Due to (or as a									
50, te be executed sysician and burial - transit	SalE	d											
760, cate be e physicia he buria	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Da										3d. Date of deli	very	
Box 68760, te death certificate by the attending physic left for use as the but left left for use as the but left left left left left left left lef	Physician/N	23b. Was decedent properties of the past 12 months? 1 Yes 2 No	_		ant at time of d	acth ~	tal death her (Speci		Ectopic pre	gnancy	Ų	Month	Day Year
ires that the signed by ti		Part II. Other signific	cant condition	s contributing to	death but not i	resulting in the u	anderlying (cause give	n in Part I.	I —	_		to the cause of death? Probably 4 Unknown
cords law requ has been	Completed by									24a. Wa auto peri 1 🗸 Yes	opsy form <u>ed</u> ?		
fital Rec sician: The is certificate irector, page	B	25. Was case referre examiner?		Hospital: 1	natient 2	ER/Outpatient		O#	05.	ck only one)	Reside	ence 6 0	ther
sion of Vil Attending Physic death. ctor: After this y the funeral dir	tion: To	27. Manner of Death 1 Natural	No Pendin	28a. Date of (Month, May 11,	of Injury	28b. Time of li 2239 hrs		Bc. Injury a		28d. Describe Driver auto	how inj	ury occurred	u (c) .
	Certification	4 Homicide	Investig 6 Could r determi	not be 28e. Place	of Injury - At h	et	et, factory,	office build	ding, etc.	or Town,	State)		Rural Route Number, City ad, Pikesville, MD
To the Hosp within 24 hos To the Fune completely fi	Medical	101100110111		sician: To the best ner:On the basis o	f examination a	-							
V → 5 + 1 0 0	Mec	29b. Signature and til	tle of certifier	and manner st	ated.			License n			1		Month, Day, Year)
pa.		30. Name and address	s of person w	asself	e of death (Item	n 23a)		O.C.M.I	E. 		Ma	y 12, 2011	
		Melissa Brass	sell, MD	Assistant Med	dical Exami	ner 900 W	/. Baltim	ore Stre	et, Baltin	nore, MD 212	223		<u> </u>
St Regist		31. Date filed (Month)	Day, Year)	32. Re	strar's Signat	Urs.							

-			CEME 1 - For Amend I Registrar	Teas Type or amend State of	Print in Black #20bperfne91 of Maryland / De	Indelible In	k. Ensure A	All Copie Mental Hy	s Are Le զ giene	gible. 2011 15729	
	Physicia		1. Decedent's Name (First, I		In,g910,00/L	ertificate of L	Death	2. Date of De Month	ath Day	3. Time of Death	
	Medic Examir	cal	4a. Facility Name (if not insti		nber)		r Location of Death	May	4c. Count	y of Death imore	
	Funeral Director		5. Social Security Number 550–80–9303	6. Sex 1 \(\text{M} \) 2 \(\text{X} \) F	7. Age (In yrs. last birthda 92 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Birthplace (State or Foreign Country) India	
	yland -f show ed at	ctor	Usual Residence of Deceder 10a. State 10b. Common 10b		10c. City, Town or Pikesv					10d. Inside City Limits 1 Yes 2 □ No	
	ith the Mar 3a or 28a t be notifi	ral Dire	10e. Street and Number 4702 Three	Oaks Road		10f. Zip Code 21208		- · ·]	10g. Citizen of USA	What Country?	
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notifited at the Medical Examiner	ed by Funeral Director	11. Marital Status 1 Never Married 2	12. Was Dece Armed Fo	orces? 2 X No /e	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗶 No	an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	Bla	ce - American Indian, ick, White, etc. :: Indian	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		cedent's Education highest grade completed College (1	(Gi	cedent's Usual Occup ve kind of work done DO NOT use retired) Homemaker	during most of wor	king	Own Home		
Maryland		To Be	17. Father's Name (First, Mic	idle, Last)			18. Mother's Nar Mary	me (First, Middle,	Maiden Surnam	ne)	
	and 2 should Health and N tem 27 is ma		19a. Informant's Name/Rela			ailing Address (Street ! Three Oal					
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🗶 Crem 4 ☐ Donation 5 ☐ Of	ation 3 ☐ Removal from ther (Specify)	State cemetery, c	sposition (Name of rematory or other place ourney Cre	em. 05/1	Date 3/2011 4/11	20c. Location Woodb	- City or Town, State	
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Ser		per DVR	22. Name and Addre P.O. Box	ess of Facility Man 1413, Bal	ryland C Ltimore,	rematio MD 212	n Services 03	
30	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. He Due to Due to Due to	caused the death. Do not each line. Ad Injury (or as a consequence of): (or as a consequence of):	nter the mode of dyir	ng, such as cardiac		1.4	Approximate Interval Between Onset and Death	
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin E4 hours after death. To the F4 hours after death this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	dt 23c. If yes, ou 1	tcome of pregnancy Birth 2 Fetal death Inant at time of death nown	5 ☐ Other (specify) _	су		23d. D M	ate of delivery onth Day Year	
rds, P.	equires tha een signed nould be de	Completed by	Part II. Other significant co	iett femu	_	e underlying cause gi	ven in Part I.	1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown	
Reco	sician: The law r certificate has b irector, page 2 sl									Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
of Vita	y Physiciar er this certiferal directo	e: To Be	25. Was case referred to me examiner? Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		tient 3 DOA Oth	v at	lome 5 Resi	dence 6 A Oth	in-partient huspice	
Division of Vital Records,	al or Attending s after death. Il Director: Afte ed in by the fun	Certificate:	2 Accident Ir 3 Suicide 6 C	ovestigation Could not be	e of Injury - At home, farm, ing, etc. (Specify)	street factory office	k? Yes 2. ■No	Street and Numbers, State)	Der or Rural Route Number, Status of Court Parks Shall Brown D Randall Story and		
_	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 Med	ical Examiner: On the bas	pest of my knowledge, dear sis of examination and/or inv To the best of my knowledg	estigation, in my opini	on, death occurred	and due to the ca at the time, date a	ause(s) and man	ner as stated. ue to the cause(s) and manner stated.	
	Neith contract of the contract		29b. Signature and title of co	whseM.D.		29c. Licens	0057-46	5	4	ed (Month, Day, Year)	
			30. Name and address of pe	erson who completed cause / M · D · 283	SSMINNAS	e, Print) - 703 B	in Himor	e Mr	21	209	
	Sta Registra		31. Date filed (Month, Day, Y	1 6 2011 3	degistrar's Signature	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ may 1105 100x Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lecation of Death 4c. County of Death Examiner Hoventra mon Jomer 4 Stove 49 9 Bithplace (State or Foreign Date of Birth (Month, Day, Yea If Under 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 4-08-6928 1 🔀 M 2 🗆 F Hours Director Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a. State 10b. County with the Maryland Examiner must be notified at Director 1. Yes 2 \ No or 28a-f 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral COLAC or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 51 1 ☐ Yes 2 No Maryland 21215-0036 "natural", 3 Widowed 4 Divorced Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) MECHANIC College (1-4 or 5+) uld be filed within 7 1 Mental Hygiene. Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number/City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health and item 27 is r GERMANTOWN MO Page 1 and 2 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final advanced brain damage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner day subdural hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): months anoxic encenhalo ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery Edic pregnancy 23b. Was decedent pregnant in the past 12 months? Month Day ther (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by verious cardiar 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has I death? 1 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Finpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) May, 7, 2011 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: got up out of wheel chair, fell and hit his nead 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 6700 AM 1 ☐ Yes 2 🗷 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Collings wood Nursing Home 28f. Location (Street and Number or Rural Route Number, Rockville, Maryland determined City or Town, State) 299 Hurley Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 130, Gupta, MD Rockville, 1st Street, 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 Registrar

DHMH 17 Rev 7/2009

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MAY

11-03576 Paula A. Pollav Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aula A. Foliay		1- For State Control of Peath and Wenta Certificate of Death		2011 i. No.	10101							
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death							
Medical Examir		Paula A. Pollay	May 12, 20	11	0907 hrs							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of E Franklin Square Hospital Baltimore	Death	4c. County of Deat Baltimore Co								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		(MM/DD/YYYY) 9. Bi								
Director		214-82-0691 1 M 2xF 49 Yrs. Months Days Hours Usual Residence of Decedent	Min. July 2	5,1961 Fore	ountrMaryland							
áus	ł	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
yland 1-f show	5	MD Baltimore Baltimore			1 Yes 2 No							
Maryla	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou USA	untry?							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		4 Elmont Avenue 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	/ Specify Ves or No-		rican Indian, Black,							
eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		White, etc.								
after d	by F.	3 Widowed 4 XDivorced of Yes, Give Year of Dates:		Specify:	hite 							
hours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin during most of working life, DO NOT us		16b. Kind of Business	•							
5-0036 led within 72 hours after Hygiene. lother than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12		At Home								
15-0036 Tiled within 7 Hygiene. d other than the Medica	Ş		ame (First, Middle, Maiden Surname)									
21215 ould be fill Mental H marked	B		ret J. Lemn	Contract the second								
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: Uriem 27 is marked other to injury or other traumatic event; the Med	£	19a. Informant's Name/Relationship (Type, Print) Margaret Barnhill-mother 19b. Mailing Address (Street and Number 514 Old Home Road-I		· ·								
and 2 Health sitem 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City o								
nor Pages I ent of I rother		1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 Donation 5 Other Specify: and Cremation Ser. Belair	May 14.2011	Forest Hi	ill,Maryland							
Baltimore, permit. Pages 1 ar Department of Her Important: U ite	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility		en Senzione								
		Condrie h Mi farde Evens Fineral Charcel 8800 Harford Road-	arkville, Mar	viand 21234	Approximate Interval							
Physician Wedical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Combined effects of oxycodone and diazepam compliated Immediate Cause (Final disease a.by dilation and fatty infiltration of the right ventricle										
	1	or condition resulting in death) Due to (or as a consequence of):										
	힏	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
$\overline{}$	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):										
recuted and ransit		d										
50, te be execut nysician and	Medical	☐ AMENDED 23a,27,28a-f,per me,g917 7-7-11 sm										
876(ifficate ng phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	egnancy	23d. Date of delive Month	ry Day Year							
Box 6876 he death certificat the attending phyced for use as the	Sicial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)										
b. BC the dez	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	. 23e. Did tob	acco use contribute to	the cause of death?							
ires that the signed by the detache	2		1 Yes	2 No 3 Pro	obably 4 Unknown							
ords, w requir s been s should	Completed		24a. Was ar autops		autopsy findings available completion of cause of							
he law ate has	E O		perform 1 ✓ Yes 2	ned? death?								
Vital Reconvision: The lample of the lample	BeC	25. Was case referred to medical 26.Place of Death (Cleanminer?	neck only one)									
Physic rat this c	.0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other,4 N No DOA Other,4 N	lursing Home 5 R	esidence 6 Other	er:							
nding Ph. th. r: After ti	흲	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No	subject	ingested	oxycodone							
r Atte r Atte ter dea rirector	fical	2 X Accident 3 Suicide 6 Could not be 1 Fd 5-12-11 fd 8:20 am 1 Fd 5-12-11 fd 8		reet and Number or R	Rural Route Number, City							
Div pital o ours af eral D	Certification:	4 Homicide determined (Specify) Residence	Baltimor	e Md.	Ave.							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	29a. Certifier 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the To the Comp	Medi	and manner stated. 29b. Signature and title of certifier 29c. License number	,	29d. Date signed (M								
		0.C.M.E.	May 13, 2011									
00	ŀ	30. Name and address of person who completed cause of death (Item 23a)										
W		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, B	altimore, MD 212	23								
Sta Regist	ate	31. Date filed (Mooth, Day, Year) 32. Registrar's Signature										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month PM POWELL **Physician** 3 2011 MAY JALQUELINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🗓 F 65 216-42-8934 MD **1-1**8-1946 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 ☐ Yes 2X No Director Owings Mills <u>Baltimore</u> \mathbf{M} 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21117 Funeral 2 Duram Court Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No 11. Marital Status 1 Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: African-American 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Supervisor Computer Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Lucille Hawkins Clarence Hawkins Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15 Charles Plaza Apt. 702, Baltimore, MD 21201 Ethan David Powell/Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page Department of Important: If any Injury or Arbutus Memorial Park 5-21-2011 Arbutus, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Licenses andas 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBRAL HERNIATION 1 ADUR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 24 Hoves HEMORA AG INPRACEANIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to for as a consequence of: attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the att 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe Records. 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown is certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 2 No 1 Tyes 1 ☐ Yes this certificate Division of Vital 26. Place of Death (Check only one) Physiclan; 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 😭 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: I or Attending F after death. 5 Pending investigation Injury Director: After 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 4 Homicide within 24 hours a Hospital McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Thedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAY ZES-000 13 2011 lan

State Registrar

DHMH 17 Rev 1/2001 11595 backer

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

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31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03546 State of Maryland / Department of Health and Mental Hygiene Gerald L. Palmer 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 11, 2011 1326 hrs Medical Examiner Gerald 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's **Doctors Community Hospital** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Days Hours Months Director April 24, Country) Md. 217-92-9938 32 1979 1X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location mà 10a, State 10b. County 1 Yes 2 No 28a-f show Bervard Cocoa other than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at once. Florida within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29 Riverside Dr. 32922 USA 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced White á 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Information MD 21215-0036 Comple +2 Systems Analyst Technology 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filed 1 nent of Health and Mental Hyginnt: If item 27 is marked oth traumatic event, Be Palmer Sylvia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) Sylvia Palmer (Mother) 1315 Heartland Circle, Mulberry, Fla. Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 5/16/11 Baltimore, Md Donation 5 Other Specify. 22. Name and Address of Facility Stallings Funeral Home PA 21. Signature of Funeral Service License 3111 Mountain Rd. Pasadena, 23a Part I. Enter the disease, or comblications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death). Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transi Physician/Medical UNPENDED AMENDED of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 isigned by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 Unknown Completed has been si 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? this certificate page ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes မှ 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Operator of motorcycle that collided with a May 11, 2011 1300 hrs Natural Division 1 Yes 2 V No 5 Pending motor vehicle 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State)
Soil Conservation Rd and Beaver Dam Rd, Beltsville, M determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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Ling Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

acks

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

May 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 10. Physician/ 2011 9:00 P M Henry Jackson Pence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12353 Philadelphia Road Kingsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Ohio 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 № M 2 🗆 F Days Hours 291-26-8229 80 Yrs **Director** Mar Usual Residence of Decedent 28a-f shov 10a State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Kingsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21087 12353 Philadelphia Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Completed 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacturing Steel Worker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental File is marked of permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or and 0 Rachel R. Sullivan George Jackson Pence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Clymer Circle, Bel Air, Maryland, 21015 Rachel J. Johnson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State of Faith Cem. 5/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Nes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation he Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Dav. Year) 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

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32. Registrar's S

quare & Ste 2200 baltimore, mb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, 2011 Physician/ 7:30 P May <u>Charles Ambrose Ryan, Jr</u> Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Ellicott City <u>2540 Kensington Gardens #401</u> 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** July 17 1933 Maryland Days Hours Min. 1 🛛 M 2 🗆 F Yrs. Director 213-30-6760 Usual Residence of Decedent 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 🗌 Yes 2 🏻 No Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21043 <u>2540 Kensington Gardens #401</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces' 1 Never Married 2 Married X Yes "natural", or þ 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates:1951-1954 traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) **CBS News** News Film Editor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Honore Ginty Charles Ambrose Ryan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. 2540 Kensington Gardens #401 Ellicott City, MD 21043 Elizabeth Joan Ryan / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 5/17/2011 4 ☐ Donation 5 ☐ Other (Specify) Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licen MO1251 Approximate
Interval Between
Onset and Death
Year 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cancer of Distal Ureter disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown page 2 should be detached g 🗌 Unknown PYAN, signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 🔀 No HARLES 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 🔀 Residence 6 C Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No After this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 X Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title May 16, 2011 D0057136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10711 Huber, Birmingham Way Woodstock, MD 21163 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2011

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, Walter James Rielley 2011 10:05 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17300 Darnestown Road Boyds Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min October 29 1922 New Jersey 88 Yrs Director 578-20-6881 Usual Residence of Deceder 10a. State 10b. County the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 K No Maryland Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral with 17300 Darnestown Road 20841 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ned Forces Black, White, etc. ò þ 1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give Year or Dates. WWII Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 Widowed 4 Divorced the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than International Lawyer College (1-4 or 5+) 5+ Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Walter J. Rielley Meta Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Rielley/Wife 17300 Darnestown Road, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State May 17 2011 4 ☐ Donation 5 ☐ Other (Specify) Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licensee, Co M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dysphagia unknown Medical resulting in death) Due to (or as a consequence of): Examiner Muscle Weakness unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury burial-transi Dementia unknown that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Hypercholesterolemia should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Benign Prostate Hypertrophy After this certificate has page 2 autopsy Hospital or Attending Physician: The l 24 hours after death. Funeral Director: After this certificate h performed' Osteoporosis 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 😾 Residence 6 🗌 Other (Specify) မှ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director, Af completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to go knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete ause of death (Item 23a) (Type, Print)

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Registrar
DHMH 17 Rev 7/2009

19710 Fisher Avenue, Suite J, Poolesville, Maryland 20837

MD

Amar Duggirala, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2011 Month 133 DRIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral 7. Age (In yrs. last birthday) 1 M 2 F Min Hours 1471471926 England Director 84 464-76-6292 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral USA 1518 Eton Way 21114 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the N Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bertha Kate Brown Charles Oscar Sprake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD 21114 Mr. Michael C. Roberts/Son 1518 Eton Way Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 19 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Stephens Church 2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation services, 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANCREA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the within 2 only one) 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Name and address of pe

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#7 Per FH G915 5/18/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 2011 Rindone 3:30P M Helen Margaret Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab Ctr. Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 TxF Months Days Hours Min Month Day, Year) 14 Yrs Maryland **Director** 214-12-9015 96 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🗶 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be i 10g. Citizen of What Country? Funeral 21401 USA 2700 South Haven Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar monee. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Mary Sroka Joseph Ozminski Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Deer Spring Court Forest HI11, MD 21050 <u>Mr. Charles Rindone/ Son</u> 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of May 20c. Location - City or Town, State Date cemetery, crematory or other place, Meadowridge Mem. Park 2011 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Ave SW Glen Burnie, MD 21061 2nd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Directo (or as a consectioned cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 month ίος Month Year Pregnant at time of death Day signed by the a ☐ Yes
☐ Unk Part II. **Other significant <u>co</u>nditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of teath? 24a. Was an this certificate has page 2 autopsy performed? 2 🗌 No 1 🗌 Yes Yes 2 N the funeral director, 25. Was case referred to ma Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 4 Hursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Norral 5 Pending 1 🗌 Yes 2 🗌 No ccident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determina Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c. License of death (Item 23a) 30. Name and address of person who 31. Date filed (Month, Day, Year State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Cegible. amend items 7,19b per fin g915 5-17-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 100 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner orien Nursias Olymbi Owar 04 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 10/11/1916 Birthplace (State or Foreign Country)
 DC Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1 X M 2 □ F Months Days Hours 94 578-05-0689 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f show Exeminar must be notified at 1 ☐Yes 2 No Director MD HOWARD COLUMBIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with in the Health and Mental Hygiene. 12290 GREEN MEADOW DRIVE, #504 21044 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Specify: 3 Widowed 4 Divorced WHITE 'natural", er than "natura 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR DRY CLEANING Ith and Mental Hygie 27 is marked other ti r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSENDORF SNEIDER MORRIS ROSE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of 9521 WINDBEST WAY, permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. PAULINE ROSENDORF / WIFE COLUMBIA, MD 21046 20b. Place of Disposition (Name of cemeter, crematory or other place)
KING DAVID
MEMORIAL GARDENS 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 05/13/2011 FALLS CHURCH, VA 22. Name and Address of Facility 21. Signature of Funeral Sc SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 9 CIV disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director After this certificate has been signed by the attending physician and filled in by the furnat director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 3 NNO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one)

29b. Signature and title of certifier

31. Date filed (Month

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29d. Date signed (Month, Day, Year)

and manner stated.

OFOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Month Virginia Snyder 10:00a M Semmes 10 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, New York 1 | M 2X | Days Min 1943 Director 68 Jan 080-34-0193 show a 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits Director 28a-f Examiner must be notified 1 🗆 Yes 2 🏋 No MD Potomac Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MAY 23a Funeral 20854 USA 11640 Partridge Run Lane tems death , 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. , or 1 Never Married 2 X Married after þ 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced 52 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Z permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea Maryland 2121 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SEMI 12 Legal Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Henderson Walter Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 5 4736 Old Dominion Drive Arlington, VA 22207 John Gibson Semmes, Jr./son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 05/14/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Sing nome Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the Csease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 5hock Physiciani disease or condition Medical resulting in death) Due to r as a consequence of) Examiner eumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ohysician and the burial-transit Stage small canter extensive cell luna resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician; 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 욘 1 № Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Ie Funeral Director: Aff 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1)0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, manyland 2550 Drive. 01 Center Midica 32. Regist ar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma^{Month} 15 ^{Da}2011 Year 10:20PM Melva C. Saynuk Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air 101 Roland Place Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Nov. 16 Months Days Hours 1 M 2 X F Min 215-40-5498 68 1942 Maryland **Director** Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Completed by Funeral 21014 United States 101 Roland Place permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify If Yes, Give Year or Dates. 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Thelma Badders Michael Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Sean M.C. Saynuk (Son) 71 Greenbriar Lane, Gettysburg, Pennsylvania 17325 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 19 ate Evans Funeral of hapel 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bel Forest Hill, Maryland Air . Signature of Funeral Service Licensee wans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill Maryland 21050 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset in Death Physician/ ocardial disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The law requires that this certificate has been stoned by the attending housing and the funeral Director: After this certificate has been stoned by the attending housing and the funeral Director. been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

33642

Hickory Avence

May 16, 2011

Be/AV MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23e, perPHYS, G916, 6/21/2011, WS
State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ Paul Simons 10:30 AM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1205 Frailey Way 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) Funeral 1 M 2 □ F Days Hours West Virginia Min March 11, 1926 225 34 2079 85 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 USA 1205 Frailey Way 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 Yes 2 XNo Specify: White 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) Steel Mill Steelworker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Garnett John Simons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 940 Wilmington Ave. Baltimore, Maryland 21223 Dawn E. Howell (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Holly Hill Mem. Garden's 5/17/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex 21. Signature of Funeral Service Licensee Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAYT Physician/ ngest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ISEASE. hulmonar 0 05 phollic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examine sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year signed by the a Id be detached f Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mEllitus 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should be 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X N within 24 hours after death.

To the Funeral Director: After this certificate t completed filled in by the funeral director, page 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🛂 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year. 29c. License number MIN 0 2011 URUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) imore Mar AMID 5901 NUTTH 110 M-1) 31. Date filed (Month Day, Year) 32. Registrar's Signature State MAY 1 7 2011 Registrar

Inthony Paul S	orre		e of Maryland								,		
		1- For State Registrar	,	•	icate of L				_{g, No.} 20	57	-		
Physici		Decedent's Name (First, Middle,L	•					Date of Deat Month	Day Yea	3. Time of Death			
Medical Exam	iner	Anthony Paul 4a. Facility Name (if not institution, s	Sorrenting		Lab	City, Town, or Lo	ocation of Death	May 12, 20	911 4c. County o	1711 hrs			
		Upper Chesapeake Med				Bel Air	ocation of Death		Harford	n Death			
Funerai		Social Security Number 6.	Sex 7. Age	e (In yrs. last	oirthday)	If Under 1 Year	If Under 24Hrs	8. Date of Bir	h (MM/DD/YYYY)	9. Birthplace (State or			
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MD nd 2 sho alth and m 27 is													
of Hee	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Date May 17, 20c. Location - City 2												
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Ball Bermit Depart Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Servi 3 Newport Drive Forest Hill, Maryland											
Physician		23a. Part I. Enter the disease, or cor	nplications that caused	the death. Do	1.3 10	-wcorr D	TIVE FO	rest Hi	II. Marv	riand /1050			
/Medical		failure. List only one cause on	each line. a. Methadone							Between Onset a Death	nd		
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ox 6 eath ce attend for use	Sicia	1 Yes 2 No 9 Unknow	Pregnant at t	ime of death	5 Other	(Specify)							
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of Vital ag Physician After this cert meral directo	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 ER/	Outpatient 3	100	nor 🗔		Residence 6	Other:			
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Division pital or Attendin ours after death. teral Director: Affiled in by the fi	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined determined (Specify) Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 919 Hillswood Ct											
E 6 6		29a. Certifier				at the time del		Bel Air	,Md.		Į,		
To the Howithin 24 h To the Fun completely	edical	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To wit	Mec	29b Signature and title of certifier	and manner stated.			29c. License n	umber		29d, Date signe	d (Month, Day, Year)			
		W-m)_				O.C.M.	E.		May 13, 201	11			
00	ŀ	30. Name and address of person who	completed cause of de	eath (Item 23a)	L							
V.		Donna M. Vincenti, MD	Assistant Medica		er 900 W	Baltimore S	treet, Baltim	ore, MD 212	23				
St Regist	ate rar	31 Date filed (Month, Day, Year)	32. Registrar	s Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death lyde Fenton Sr Smith Physician/ 0430AM 2011 12 Medical Facility Name (if not institution, ion, give street and number) VA CLRC 4b. City, Town, or Location of Death 4c. County of Death **Examiner** och Kaven Baltimore . Social Security Number 218-30-5628 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Country) 1 **X** M 2 □ F Days Hours Min. 75 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 201 N. Washington St Apt1203 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 No If Yes, Give ₩WII
Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Auto Parts Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Telisha Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Smith, Jr./Son 3 Deer Glen Ct. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 5/24/11 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityBeverly D. Cr 2700 Edmondson Ave Balto., Cromartie F/S Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Stage Renal Disease Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? ☐ Live Birth 2 ☐ Fetal deat
☐ Pregnant at time of death
☐ Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrilliation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 5-12-2011 D0069441 30. Name and address of person who completed cause of death (Item 23a) (Type Print).
Sepiden S. Dadras, 3900 Loch Raven Bowleverd, Baltimore MD 21218 31. Date filed (Month, Day, Year) 32. Registra 's Signature 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ·955448 Vivian Ester Batson Strothers 10:55.4M 2011 STROTH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City,
A
If Under City, Town, or Location of Death CIT SINAI HOSPITA1 timore 5. Social Security Number Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 9-13-1920 219-14-0146 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be mitthed at MD Baltimore Director 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4415 Wentworth Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give ?* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 □Yes 2 →No Specify: Specify: African-American Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Brooklyn College of Arts permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If Item 27 is marked other that any Injury or other traumatic event, Insponse. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angus Batson Mamie E. Hogan P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elbert Walker Strothers/ Husband 4415 Wentworth Road, Baltimore, MD 21207 20a. Method of Disposition Entarionent 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-2011 Woodlawn Cemetery Woodlawn, MD 22. Name and Address of Facility Wlie Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each life. 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AtheroscheroTic Hearl Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to mini chatte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physiclan: The within 24 hours after death.
To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 2 **X**No 1 □Yes 2 000 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 82242000 30. Name and address of person who co inpleted cause of death (Item 23a) (Type, Print) SINAI HOSPITAL of BALTIMORE IRMO SPIZIC 31. Date filed (Month, Day, Year) State MAY 17 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 16 2011 8:50 AM Sadler Мау Richard Alan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Cherry Lane Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Yea BC 25 Days Hours Min Country) Maryland 1 🕅 M 2 🗆 Director 216-28-5649 77 Usual Residence of Decedent aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Prince George's Laurel 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9605 New Orchard Drive 20774 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", Specify: 3 Widowed 4 X Divorced White Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N U.S. Postal Service Procurement Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Ida Jeffries Raymond Pius Sadler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 New Orchard Drive, Largo, MD Dorothy Schultz/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 5/17/2011 Odenton, MD 4 Donation 5 Other (Specify) West Arundel Crem. Donaldson Funeral Home, P.A. nature of Funeral Service Licenses 22. Name and Address of Facility 20707 313 Talbott Avenue, Laurel, MD M01103 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Case (Final disease or conditions) Approximate Interval Between Opset and Death Physician Unknown Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No as been signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes, Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Peripheral Vascular Disease 24a. Was an Jas autopsy page performed?

Yes 2 No certificate l Anemia 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🗶 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 XNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury safter death.

I Director: Aff
I in by the fu M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, raven D006/66 May 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Hickory Ridge Road, Suite 215, Columbia, MD 21044 Fredisia Francis, MD . Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 17 2011

Registrar

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Maryland 21215-0036	permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates.			f Yes, spec		, Mexican, Puert Specify:	o Rican, etc.)		Black, Specify:	White, e			
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Ba	permi Depar Impor any ir once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTIMORE MD													
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			30. Name and address of person who d	completed cause of de	eath (Item	23a) (Type, P	Print)	0 7	513		1110	7-11-	001			
11	J		Dr Court ney 1	1 CC/ USK	ey)	9000	Fran	Klin	Square	Drive B	alt	moce	MI	215	3.7	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 21:05 DCHAEFER MAY 2011 00 Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death MARYLAND BALTIMORE ENTER NIVERSITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours July 14, New York Director 72 1938 089-30-6901 Usual Residence of Decedent or 28a-f show e notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Harford 1 Yes 2 No Bel Air 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? pe 23a Funeral ed other than "natural", or items 23 event, the Medical Examiner must 21014 412 E. Ring Factory Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Registered Nurse Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ þe traumatic Leroy Sloan Richardson Gertrude (UNK) Beuerle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 f Health a Henry Schaefer / Spouse 412 E. Ring Factory Road, Bel Air, Maryland 21014 t: If item? Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 5-12-11 Towson, Maryland Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MYELOZD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal 352 in the past 12 months? Day 9 Unknown g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 2 No Yes 2 X No 1 Yes of Vital Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certific funeral director. Be 25. Was case referred to medica! 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division 1 Yes 2 No Accident М Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number B18938 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASSHANN TREGORY GREENE ST BALTIMORE, MD 21201 31. Date filed (Month, Day, Year)

MAY 1 7 2011 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day MAY 2011 Year Sarah Stump Streett 11 9:30p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** onth, Day Ye Country) Maryland Year 1966 1 🗆 M 2 📭 Months Days Hours Director 219-88-2411 45 Feb. Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location must be notified at 10d. Inside City Limits Director Maryland Harford 1 Yes 2 No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 'natural", or items 23a 2612 Cool Spring Road 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wilson Stump Sally Sarah Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Paul Streett / Husband 2612 Cool Spring Road, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Important: It any injury or once. Hilltop Service Corp: 4 Donation 5 Other (Specify) 5/14/2011 Towson, Maryland 21. Si natura di Funeral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betweer Immediate Cause (Final Breast Onset/and Death Metastatic Physician disease or condition resulting in death) yr S Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of 29c. License number 00056919 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 Robert Donegan, Charles St #205, Towson, Maryland 21204 31. Date filed (Month, Day, NAY 1 State Registrar

Stree M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 7:50PM M Anna Mary Slouck 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Nursing & Rehab Sykesville Carroll Birthplace (State or Foreign Country)

MD If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth March 20, 1 M 2 X F Hours Min 93 215-56-7943 Director MD Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 1 🗌 Yes 2 🙀 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1930 Refreshing Mint Drive 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawrence E. Shue Isabella Virginia Lutsche 19a. Informant's Name/Relationship (Type, Print) (Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 Refreshing Mint Drive, Westminster, MD 21157 Mrs. Virginia A. Birmingham 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Cedar Hill Cemetery 5/16/2011 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA TELL 400764 Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lift Interval Between Immediate Cause (Final Duren Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Causa (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should peen Were autopsy findings available 24a. Was an has prior to completion of cause of death?

1 Yes 2 No autonsy certificate director. 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 1 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral a 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 21136 BUSINEST

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 5:42 A M SPOON OTIS RAY MAY 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville 1402 Gladstone Drive Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min April 26, 229-74-1703 60 1951 Virginia **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 20851 United States 1402 Gladstone Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 XYes 2 NoVIETNAN Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes, Give 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates -ERA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electronics Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Mann Spoon Author 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Gladstone Drive, Rockville, Maryland 20851 Spoon /Wife Cornelia Matthews 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🛘 🗆 Burial 2 ី Cremation 3 🗀 Removal from State Bethesda, Maryland Montgomery Crematorium, Ind 4 ☐ Donation 5 ☐ Other (Specify) 201121. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland nexitation M01305 20850-2805 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOPULMONARY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions i any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to joi as a consequence of Exami ESSENTIAL HYPERTENSION the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Day Pregnant at time of death 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 s autopsy performed? Yes 24 No certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 \ No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d, Describe how injury occurred iniury 1 X Natural 5 Pending 2 🗌 No after death Director: / I in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, the Funeral Directory filled in by 4 Homicide determined City or Town, State) Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 ho

To the Fune

completed fi

PATRICIA ANN WRIGHT, M.D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Sig State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one

29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

MD# 13140

29d. Date signed (Month, Day, Year)

MAY 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13^{Day} Physician/ 201^{Ypar} May Shaffer Jeanne Davis 11:00A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Anne Arundel Glen Burnie Health & Rehab Glen Burnie If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 10/11/1929 1 🗆 M 2 🕮 Hours Yrs. **Director** 215-24-1169 81 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1544 Hodges Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve ၉ Yoak James Davis Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 Mr. Robert Shaffer / Husband 1544 Hodges Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2011 Glen Burnie, MD Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Exmer 1- ac Physician/ Agrance disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery [☐ Live Birth 2 ⊡ reเลเนอด ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year pec the n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29b. Signature an 29c. License number 29d Date signed (Month, Day, Year) MY 0 63726

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayonth Pey 2011 12:34 A M Pearl I. Steinacker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 2820 Hoffman Avenue Lansdowne 5. Social Security Numbe 217-16-8413 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 6, Year)924 1 M 2 X I 86 MaryTand Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Baltimore 1 Yes 2 No Lansdowne 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2820 Hoffman Avenue United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 10 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meagnee. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8th N/A Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Ensey Raymond Ensey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Keirle/ Daughter 2820 Hoffman Ave.,Lansdowne, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Ma Cyrule D. Grenva D 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) May 13,2011 Crownsville, Maryland Cemetery @ Crownsvillė 21 Signature of Juneral Service Licens AMBROSEA FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry RD., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DAYLI LRINARY TRACT INFECTION Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury KLOWTHS attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed PULMOWARY EMBOLISM that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Yes 2 No 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VERTEBRAL MARS 1 Yes 2 No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should MULTIPLE MYELLOWA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fi Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D0070917 MID MAY 10,2011 3455 WILKENS AVENUE - SUTTE LLID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RALTIMORE, MARYLAND

State Registrar 31. Date filed (Month, Day, Year)

7 2011

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:53 AM **Physician** Iramia 71/11/10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday) **Funeral** 59 Months Days Hours Min 252-72-0918 1 M 2X F PA 09/05/1951 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore MD 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 1025 S. Clinton Street 21224 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner and any injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Finances Financial Analyst 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ozelle Copeland Malema Egbert Stirling Harry မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard C. Stirling/Brother43227 Kathleen Elizabeth Dr., Ashborn, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodbine, MD 5/18/2011 Final journeycrem 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota, Marshall 21203 Mae Shell Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final right fernoval neck fracture with complications **Physician** disease or condition resulting in death) /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, CENTERCATION APPROVED BY MEDICAL EXAMI the death certificate be executed burial-trar and Due to (or as a consequence of) nding physician use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy atten for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) been signed by the at should be detached to 2 🗌 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has 1 TYes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner 1 Hospital: 1 | Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 🗌 No 2 ER/Outpatient 3 DOA P completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: al or Attending P s after death. I Director: After t Injury 1 Natural 5 Pending investigation 5/4/2011 fall 2 Accident 3 Suicide unichoun M 1 Yes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)

At home

City of power state.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 4 Homicide 24 hours Hospital 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, Res - 000

State Registrar

DHMH 17 Rev 1/2001

Nitya MD Rai 31. Date filed (Month, Day, Year) 32. Registrar's Signature 7 2011

600 North Wolfe St, Baltimore, MD, 21287

OCME

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15^{Day} Month MAY 20 Î 02:25A M SLIVKO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STERLING HOSPITALITY BALTIMORE Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Country)POLAND Months Days Hours 0671371916 94 Yrs Director 173-26-5763 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7015 PARK HEIGHTS AVENUE 21215 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 🛮 Widowed 4 🗆 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REITZAH ZOTLYA SHLOMO CHIRGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 5308 SUNNY FIELD COURT, ELLICOTT CITY, MD 21043 SHULAMIT FINKELSTEIN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MT LEBANON 05/16/2011 COLLINGDALE, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician DEHYDRATION weeks Medical resulting in death) Due to (or as a consequence of) Examiner DEMENTIN ALZHEIMERS 10 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to forms minor secuence of sician and burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death detached Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed Yes 2 2 No 1 Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 힏 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) injury 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 030377 15,2011

State Registrar

DHMH 17 Rev 7/2009

6503 PARK HEIGHTS AVE

BALT, MD ZIZIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

RIBERT M. COOPER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ETU, M Month Physician/ Medical 4c. County of Death Examiner would CRISTERIE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 147254 1917 1 ☐ M 2 🗓 F Months Hours MD 93 **Director** 215-01-5441 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must ha matter at 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2X No BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21209 2501 OZARK CIRCLE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည AMELTA BOOK ROTHMAN MILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 OZARK CIRCLE, BALTIMORE, MD HARVEY SNYDER/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 05/16/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) NEUNONI Medical Due to fr as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury as the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 5 Other (specify) detached the Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsy death? 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Mann of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred Natural (Month, Day, Year) iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Medical 🔂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: To the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9502

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item/23a) (Type, Print)

31. Date filed (Month, Day, Year)

Division of Vital Records. PO. Box 68760.

		State of Maryland / De			_		
		1_ State	ertificate of Death		0011 1		
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/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 1009 10	Ic. County of Death		
LACITII	IICI	Johns Hopkins Bayview Medical Center	Baltimore				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)		
Director		213-06-1236	Months Bays Hours Min.	03/27/19			
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Maryla f sho	Ď		•		1 X Yes 2 No		
the l	Director	MD Prince Georges Greenbe	2 Lt 10f. Zip-Code	10a. C	Ditizen of What Country?		
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death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,		
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d be ental ced o	To Be	Ellis Lee Taylor	Patric	ia Rubv	Drzowale		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	-		iling Address (Street and Number or Ri		y or Town, State, Zip Code)		
of and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Patricia Humphrey / Mother 408	B Ridge Road, Apt.	8. Greenbe	elt. MD 20770		
permit. Pages 1 and 1 Department of Health Important: If Item 27 any Injury or other tra		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		Location - City or Town, State		
Pages nent of int: If I		The banks Electronical of Tremoval north State		6/2011 Hai	nover, Maryland		
permit. Departn Importa any inju		21. Signature of Funeral Service Acensee			ts Registry		
88258			7522 Connelley Dr.	, Ste. P, I			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failur. Hist only one cause on each ling.	nter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset_and Death		
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/Medical Examiner		resulting in death) Due to (or as a consequence of):	2 1 1 4	2 /			
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hysic this co	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		4 Nursing Home 5 Hesidence 6 Other (Specify)			
Iling F	io	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Natural 5 Pending (Month, Day Year) 2 Natural 5 Pending (Month, Day Year)	Work?	28d. Describe how in	28d. Describe how injury occurred		
death death stor: /	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s		28f. Location (Street and Number or Rural Route Number,			
after Direction by	te)						
spital nours neral	C	29a. Certifier Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.		
e Ho: e Fur	edical	(check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occi	urred at the time, date a	and place, and due to the cause(s)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
		· Cla.	D005512	22 M	ay 10. 2011		
•		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	,	1010		
		Juan K. Carmazoma +	1. <u>5</u> . 4940 E	astern Aveni	ue, Baltimore, MD, 21224		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature					
negisi	TEL T	BRILLICUIT (ALMOR) A. APROF					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Ma Physician/ HOMAS Medical **Examiner** Age (In yrs. last birthdav **Funeral** 8. Date of Birth 1 🗆 M 2 🖲 6-6-1954 Director -68-56 rs. 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 No ò 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO (19) use retired) (Specify only highest grade completed) than nday (0-12) Elementary/S College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Be Eather's Name (First, 18. Mother's Name (First, Middle, Maiden ၉ formant's Name/Relationship (Type, Pr 20a. Method of Disposition ace of Disposition (Name of metery, crematory or or Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sign were of Funeral Service Licen-Part 1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Ph_sician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): the attending physician and hed for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month page 2 should be detached Unknown 9 Unknown g signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 Yes 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation 1 🗌 Yes 2 🗌 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier State

DHMH 17 Rev 7/2009

Registrar

Division of Vital Records,

Baltimore, Maryland 21215-0036

GN.

requires that the death certificate be P.O. Box 68760

> State Registrar

31. Date filed (Month, Day, Year)

BICH DUONG, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BICH DUONG, WD 724 MAINSON CHOICE LANCE BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Month 8:00 P M Physician/ May 2011 Charles Karol Teryek Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford 929 Rumsey Place Joppa 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Aug. 23, Year 1926 **Funeral** Hours New York Months 1 🕱 M 2 🗆 F 84 051-24-5094 **Director** Usual Residence of Decedent 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Joppa Maryland | Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 21085 929 Rumsey Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc. ð 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mexany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Supervisor Procurement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Julianna (unk) Nagy Charles (unk) Teryek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
929 Rumsey Place, Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type, Print) Mary Ellen Teryek / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland Harford Memorial Gdn 5-13-2011 21. Signatur / Funeral Service Licenser 22. Name and Address of Facility McComas Funeral Home, P.A 1317 Cokesbury Road, Abingdon, Maryland 21009 Dantivaria athless 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mouths Encepha Anoxic lona Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Yea Day in the past 12 months? 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Discase þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page 2 performe 1 Yes 2 No Yes 2 this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? or Attending Physician: funeral director, Be Other: 4 Nursing Home 5 X Residence 6 C Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: After 1 Natural 5 Pending 2 Accident Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29d. Date signed (Month, Day 29b. Signature and title of certifier A35012 2011 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 LYNCH J. Kevin 31. Date filed (Month, P Registrar's Signatur State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Tobias Robert Donald. 2011 13 1:00 P M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 ፟ M 2 □ F Hours November 6 New York 1923 Director 564-26-8005 87 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Tyes 2 No Maryland N. Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 13500 Query Mill Road 20878 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. WW 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed II Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Arts & Film Independent Film Producer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Stephanie Shank Tobias So1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13500 Query Mill Road N. Potomac, Maryland 20878 Tina M. Tobias / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) May 16, 2011 Crematorium. 21. Signature of uneral Service Li Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 tu MO 1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. **Other** sig<mark>nificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No I Director: After to a in by the funeral Certificate: 28d. Describe how injury occurred K Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 109 Rox enter Prive. ch 32. Registrar's Signature State 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 301 2112 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Baltimore Catonsville 515 South Rolling Road 8. Date of Birth Age (19 yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 1 □ M 2 🕱 F Hours (Month, Day, Year) 217-03-2974 MD **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 0a. State rector Catonsville Baltimore 1 Yes 2 x No ā 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21228 515 South Rolling Rd. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 💥 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Salesperson Be 18. Mother's Name (First, Middle, Maiden Surname)
Harriett Rogers 17. Father's Name (First, Middle, Last) မ James W. B. Phillips 19a. Informant's Name/Belationship (Type, Print) Lisa Ricklin, granddaughter 1951 Mailing Address (Skeetend Number Referral Cate Number Fitz Prefown Migte, Zig 90228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 05-15-2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ roumon disease or condition Medical resulting in death) Duk Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Other (specify) Pregnant at time of death 1 Yes 2 g Unknown been signed by the a should be detached to Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy perform death? Yes 2 No 1 ☐ Yes 24 25. Was case referred to examiner? the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of pe State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ William Thomas Ulsch, Jr. 2017 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air 6. Sex 1 🖾 M 2 🗆 F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. Day, Yea 217-50-2076 64 Months Davs Hours 1946 Baltimore, Maryland Director Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 U.S.A. 1116 Scalding Drive Unit E Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? Black, White, etc. 1969 þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 1972 Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Steelworker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Ulsch, Sr. Dorothy Birmingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Spalding Dr. Unit E, Bel Air, Maryland 21014 Mrs. Claire Ulsch (Spouse) 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evars Furerally Chapellace, Bel Air Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licenses Jeffrey R. ²Evans Furerap Univel & Cremetion Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 toman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear) failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) tdeno carcinome Medical Due to (or as a consequence of): **Examiner** Failure enal Sequentially list conditions, Examine dany, leading to immediate cause. Enter Underlying Metabolic been signed by the attending physician and should be detached for use as the burial-transi or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iiniur) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes ∠ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work's Division s after death. Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vear Month 720 PM ANNE edit2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death #207 POMONA EAST, BALTIMORE PIKESVILLE Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 ENGLAND **Funeral** 1 Year If Under 24 Hrs. 1 M 2 X F Months Hours Month Day, Year) 09 216-09-4000 **Director** 101 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2 POMONA EAST, #207 21208 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ADMINISTRATIVE ASSISTANT ALMO PRODUCTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES COHEN **FANNY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY C VEDITZ / SON 2409 DIANA ROAD, BALTIMORE. MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 05/13/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. mars 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ Medical Examiner Ihrillatar neal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by +VAC+ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending iniury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hou، the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 2700 Quany Loke Dive Baltonia Md 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANFORD 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vernon В. Wright 3:15 p. M 2011 May 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2707 Spellman Road, Apt B-1 Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1**▼** M 2 □ F Days Hours 08/25/1950 215-56-6366 60 Director MD Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f s MD Baltimore 1 X Yes 2 No 20 10f. Zip Code 10g. Citizen of What Country? Funeral 2707 Spellman Road, Apt B-1 items 23a 21225 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Driver Transportation any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vern Wright Carrie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Gasque-Wright 2707 Spellman Road, Apt Bl, Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

St Lukes U M Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/14/2011 Monkton, MD 4 Donation 5 Other (Specify) 21. Smatur of Funeral Service License 22. Name and Address of Facility Howell Funeral Home, Liberty Heights Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Heprocelly disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HERAT. T.S 2 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the k IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes or Attending Physician; director. æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Jo 1 Inpatient 2 ER/Outpatient 3 IDOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature an 29d. Date signed (Month, Day, Year) DO H0062554 MAY 13 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 BALTIMOR, MD CYNTh:A Shen Richy Hospite Do

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 17 201

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DHMH 17 Rev 7/2009

State

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

JONES,

31. Date filed (Month, Day, Year,

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CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAMS JOQUETTA Month 12:38 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** 4c NA HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian. Yes 2 No If Yes, Give Black, White, etc. Completed by Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 🗆 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DQ NOT use retired) econday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, Williams Jones 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 101 111 1 Burial 2 Cremation 3 Removal from State Important; Il any injury or remators 4 ☐ Donation \$ ☐ Other (Specify) Signature of Experal S lice Lice Bosto MU 21229 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Between Party. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Gause (Final Onset and Death Physician/ END STAGE RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed YEARS HIV iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Year 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATITIS C, HYPERTENSION, PML, CVA, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC DIARRHEA, CHRONIC PANCREATITIS 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 \sqrt{Yes} 2 \sqrt{No} 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHETH

31. Date filed (Month, Day, Year)

RESOO

3001 S. HANOVER ST BALTIMORE, MD

2011

MAY 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 2011 Medical 4a. Facility Name (if not institution, give street and numb 4c. County of Death Examiner Center 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 KM 2 🗆 F Director 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a alter 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or þ 1 Never Married Married ☐ Yes 2 ☐ No Give Maryland 21215-0036 1 Yes 2 No Specify. and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nday (0-12) College (1-4 or 5+) Be Name (First, Middle, Last) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is SON altimore. 20a. Method of 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signat of Funera Service Dicenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of twing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month. Veal Pregnant at time of death detached g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? The law has autopsy perform 4 certificate 1 Yes 2 No Division of Vital or Attending Physician: the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After of completed filled in by the funer. 5 Pending Natural work? 1 Tes 2 🔲 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear ustal Woolndge Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Secours Huspital Battimore 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Funeral 1 M 2 H Days Hours Min Months 217-98-1200 29Yrs. **Director** Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Baltimore City Maryland 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or idical Examiner must be with 1 Funeral 411 Vincent St. Inited States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent ____ Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examinany injuy or other traumatic event, the Medical Examinany in the Medical Examinant. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Candy Black Ronald Woolridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 Benson Ave., Halethorpe, Maryland 21227 Rona1d Woolridge / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 13,2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. Signature of Funeral Service Li llan 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arry thmy disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Hyperkalem ia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed stage and the burial-tran that initiated events resulting in death) Last Due to (or as a const quence of) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death ☐ Pregnam
☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 FR/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) affending D0056240 Marcia Cost, mo Physiciam

Hogoital 2000. W. Baltimore Street, Battimore MD 21223

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-03395

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_ouis Washington	R	State of Maryland / Department of Health 1-For State Amend Item 8 per fh, g927, 17, 20, 20, 11 dh Registrar	and Mental H		2011	15772	
Physician Medical Examine	7	1. Decedent's Name (First, Middle, Last) Louis Washington		2. Date of Death Month May 5, 201	Day Year	3. Time of Death 1125 hrs	
	•	4a. Facility Name (if not institution, give street and number) 4b. City, To Baltim	own, or Location of Death ore		4c. County of Death		
Funeral Director	L	5. Social Security Number 2 1 4 - 5 8 - 9 5 7 0 6. Sex 1 Months 7. Age (In yrs. last birthday) 5 6 Yrs.				thplace (State or in MD unitry)	
ath with the Maryland items 23a or 28a-f show any ust be sotified at once.		Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location Balti				10d. Inside City Limits 1 X Yes 2 No	
the Maryland 3a or 28a-f sh otified at once		10e. Street and Number 1613 Ashland Avenue	21205	109	g. Citizen of What Cou US	A .	
p sel	by runeral	Armed Forces? If Yes, specify Armed Forces If Yes, specify	nt of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No specify:	Rican, etc.)	White, etc. Specify:	ack	
036 ithin 72 hours: ne. telan "naturi fedical Exami		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	king life. DO NOT use reti	red)	Restaura		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic evect, the Medica	8	17. Father's Name (First, Middle, Last) Robert Elwood Matthew		y Washi	ngton		
MD 21 2 should h and Me 27 is man		La-Kesha L. Martin /Daughter 2615 E.		., Balt	imore, M	D 21213	
Baltimore, Permit. Pages I and Department of Healt Important: If item injury or other train		20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Nam crematory or other place) Final journey		Date 6/2011	20c. Location - City or Woodbine,		
Baltir permit. I Departm Importatiojury or		21. Signature of Funeral Service Licensed Orota Marshall 22. Name and	Address of Facility Maryland (PO Box 141	13. Bal	timore. N	<u> 1D 21203 </u>	
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis of the liver and the complete cause)			st, shock, or heart	Approximate Interval Between Onset and Death	
and the second		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of):					
uted nd ransit	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
	edical	x UNPENDED AMENDED 23a, 27, per me, g917 7	7-8-11 sm		23d. Date of deliver		
Vital Records, P.O. Box 68760, side in: The law requires that the death certificate be his certificate has been signed by the attending physici director, page 2 should be detached for use as the bunicator.	Pnysician/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spec	3 Ectopic pregna	ancy		Day Year	
P.O. Brest that the designed by the be detached	6	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		pacco use contribute to		
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the safer death. The range death of the this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed			24a. Was a autops perform	prior to death?	utopsy findings available completion of cause of es 2 No	
sician: Sician	å l	examiner? Hospital: 4 Innation 3 FR/Outpatient 3 D	26.Place of Death (Check		Residence 6 🗹 Othe	r: Scene	
ision of Vita Attending Physicia or death. by the funeral direct	0 :: 0 ::	1 Yes 2 No	8c, Injury at Work?		ow injury occurred		
Division of North Robits of Attending Phywitin 24 hours after death. To the Fuorral Director: After to completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Specify 1 Nomicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Divi	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	Me		O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)	
8	-	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Bali	timore Street, Baltin	more, MD 212	223		
Sta Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature					
DHMH 17 Rev 1/200 OCME 2006	_	ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 2011 10! /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Daltimore Luter If Under 24 Hrs 8. Date of Birth Month, Day, If Under 1 Year 7. Age (In yrs. last birthday 5. Social Security Numbe **Funeral** Months Days Hours South 1 M 2 □ F 83 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or itams one any injury or other trainments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore 1 XYes 2 □ No Funeral Director ud 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 2122 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Never Married 2 Married Yes 2 Yes, Give 2 □ No 1 □Yes 2**1**No Specify: Black þ 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) Elementar 18. Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) Be known ည -hown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prir 21229 03 20b. Place of Dispo 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State -20-201 4 Donation 5 Dother (Specify) Signatur of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the caused the shock, or heart failure. List only one cause on each line Do not enter the mode of dying, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes & DNO 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death filled in by the 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) witz s 21 N 2. Registrar's Signature 31. Date filed (Morith, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State Registrar NEETA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 15 Physician/ 2:20 AM Month mar 2011 Medical 4a. Facility Name (if not institution, give street and number, nty of Death ரு, or Location of Death 4c. Co Examiner ALTI MORE 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign Country) and Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months 1 M 2 🗆 F (40nth gay, 494) Yrs. Director Usual Residence of Decedent or items 23a or 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at Director Ba 1 Yes 2 No more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Norton 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 14 Yes 2 1

If Yes, Give Black, White, etc 1 Never Married 2 Married ğ 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Torne Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Jman oi Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Salto 74 toni onstance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, cremato 8-2011 Signatule of Funeral Service Licensee Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACVIE INFARCTION MYO CARPIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTIER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy completed filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2. No Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pendina injury 2 🗀 No within 24 hours after death. To the Funeral Director; A 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number D0051865 the 201 HUSPITAL AGNES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 MARLES BALTIMURE 21229 CURTIS 900 CATON

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 8:05 Eleanor Kerbin Adrion 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lis b oasta1 comico If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Months Days 6/9/1925 Year) Hours 85 MD Director 220-12-1811 Usual Residence of Decedent mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ¹X☐ Yes 2 ☐ No Salisbury MD Wicomico 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral USA 313 Carey Ave. 21804 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Super market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cornelius N. Smack Pearl Holston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$13 Carey Ave. Salisbury, MD 21804 Oliver C. Adrion (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ 9ther (Specify) 5/5/2011 Bates Cemetery Snow Hill, MD 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CERIBROVASCULAN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for ea's consequence of If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna5 ☐ Other (specify) Month Year Day Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 2/☐No 3 ☐ Probably 4 ☐ Unknown been ; 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy death? within 24 hours after dearr.

To the Funeral Director: After this certificate I 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work?
1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying hysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Cyatifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certifier D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:15 2011 04 JOSEPH KOFI AMANKWAH Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Prince Georges Washington Washington Hospital 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours M 2 🗆 F Months 12/16/1930 Ghana 229-35-2531 80 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 No Ft. Washington Prince Georges MD 10f. Zip Code 10e Street and Numbe 10g. Citizen of What Country? 5 or items 23a Funeral USA 20744 12004 Ishtar Street death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No 1 Never Married 2 XMarried \$ Specify Black Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ghanaian nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Government the 5+ Senator permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Afua Kisiwaa Kwame Akwah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12004 Ishtar St.Ft.Washington,MD 20744 Beatrice Amankwah 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) cerian Cem. 17/2/2011 | Badu. Ghana 22. Name and Address of FacilityGreene Funeral Home Presbyterian Cem. 17/2/2011 21. Signature of Funeral Service License elson 814 Franklin St.-Alexandria, VA 22314 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final udi D Physician/ disease or condition resulting in death) 🗼 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the and be detached f g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 L No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 hours after death.

-uneral Director: After this control of filled in by the funeral director. 1 Tes ည 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in magnification in magnification in magnification. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd Ste 308 FT Washington MD 20744 age State

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Registrar

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
ILena 0. Bowman 2. Date of Death 3. Time of Death 05-01-20 Pg **Physician** 11:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil 16 Laurel Road Perryville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 👿 F 84 246-36-2250 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. In Medical Exp., increment to notified a once. 1 ☐ Yes 2 ☐ No Director Maryland Cecil Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 United States of America 16 Laurel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ina June Johnson Guy West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Lawrel Road, Perryville, Maryland 21903 19a. Informant's Name/Relationship (Type. Print) Charles Bowman (son) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham Cemetery 05/05/2011 Colora, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Conditions that initiated events Due to (or as a consequence of) Examine burial-transi and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Pulmonary Fibrosis Completed 24b. Were autopsy findings available prior to completion of cause of death? Pheumonia cate has by page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

M.D.

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30. Name and address of person who completed colors of death (Item 23a) (Type, Print)

M.D.

29c. License number

D 0063981

Havre de Grace, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Vear 11:15 Helen Marie COBB May 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Williamsport Washington If Under 1 Year | If U Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours Months 1 □ M 2 🕅 F Days **Director** 88 Rhode Island 028-12-7551 29 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be mylfind at Director 1 ☐ Yes 2X No Maryland Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 11. Marital Status 14 Race - American Indian filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No White ģ If Yes. Give Specify 3 X Widowed 4 ☐ Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Heatth and Mental em 27 is marked o ဂ္ Martin Arzamarski Isabella McNeill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny M. Cobb - Son 18323 Rockland Drive, Hagerstown, Maryland 21740 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 5 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 5/5/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part : niter the disease, or comblications that caused the death. Do not enter the shock, or heart failure. List only one cause of wach line. mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Priset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (of as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐NO P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 □Yes 2 **X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 4 hours after death. Funeral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). sr: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signat ed (Month, Day, Year) 29d. Date sign

OH-24

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

no completed gause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Ella Crossley Month 0 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18748 Preston Rd. Washington County Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth May 11,1916 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Marviand 220-40-0137 Director 94 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 1 🗆 Yes 2 🛣 No Maryland | Washington County Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 18748 Preston Rd. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 □ Divorced "natural", Completed of Health and Mental Hygiene.

Item 27 is marked other than "natuother traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic evenes. Edwin Coleman Hook Ella Virginia Spamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Crosslev-son 18748 Preston Rd. Hagerstown, MD 21742 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory 5-4-2011 Smithsbug, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending hours and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **To the Funeral Director:** After this certificate has been a completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2011 MAS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Amend #17 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 5—2—11 KAH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}2011 April 27, Suzanne Cowdrey Medical 3:44 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 18 Silverwood Circle Apt Annapolis Arundel Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F 214-52-8524 Months Director 64 2/16/1947 Florida Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland Control of the Ma 10a. State 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Silverwood Circle Apt 9 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 😾 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Row Cowdrey Roy Cowdrey Annette Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 City Gate Lane, Annapolis, MD 21401 Dan Cowdrey - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State Baltimore Crematory 5/2/2011 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Myclin T. Wolvert 147 Duke of Gloucester St, Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Day ed by the a detached f P.O. sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate ! perform 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? within 24 hours after death,

To the Funeral Director: A
completed filled in by the ft 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott 2002 MEDICAL PKWY, ANNAPOLIS, EDEN 31. Date filed (Month, Day, Year) 32. Registra 's Signature State MAY 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day} Physician/ 2011 Year Bernard Jermiah Crowley 04 11:18 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1**X** M 2 □ F Days Min. 09 23 Hours T957 Director DC 53 214-70-4668 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3324 Gumwood Drive 20783 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian. Armed Force 2 X No ģ 1 Never Married 2 X Married ☐ Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Hygiene. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygien Bakery Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Alan Crowley Mary Elizabeth Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n Giovanna Crowley / Wife 3324 Gumwood Dr. Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 05/05/2011 Brentwood, MD vice Licen 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Effer the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ast ati Carcinomo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by the a ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Tunknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2-1 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29/2011 een Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, mD 20912 Ave -7600 Carroll Sharma, 31. Date filed (Month, Day, Year, NAY 0 3 2011 32. Registra's Signal.

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0212 AM Karin May hane Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tomore 24 If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Year) 214-42-3168 1943 Washington, Director 67 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene.
Important if finen 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12200 Brittany Place 20708 IISA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Mamied If Yes, Give 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's County Elementary/Seconday (0-12) College (1-4 or 5+) School Board School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Hoyle Laura Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny M. Chaney / Daughter 12200 Brittany Place, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 5/6/2011 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) umor Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Sep5;5 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes I Director: After to in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sr. :304 M ph mer Use Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (Inot institution, give street and number) Examiner 3204 Brac beurse a-1620 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign Social Security Number If Under 1 Year Months Days **Funeral** Maryland 1 🛣 M 2 🗆 F Days Hours Min. 4-30-1923 Yrs. **Director** 220-16-4778 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must han material. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Upper Marlboro <u>MarylandPrince George</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13204 Van Brady Rd 20772 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black 3

Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) P.G. Board Of Elementary/Seconday (0-12) College (1-4 or 5+) Education Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tolson Susie Farmer Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4112 Skyline Dr.Suitland MD 20746 Joseph A. Farmer Jr/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Clinton MD 5-9-11 Resurrection 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Assivation Pheumonia Medical resulting in death) Due to (or as a nsequence of): Expired Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dualto for sels nonescuance on 30 Am Parkinsons To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Disease Heart pertensive Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🕱 No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Akrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Solish 5.2.11 D35295 JUMFMI. SATISH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Particles Suite 208 Drive 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State **Begistrar**

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

Amend Items 2,28a-f per dr., 9918,08/1//2011dhb

2,28a-f per dr., 9918,08/1//2011dhb

Reg. No.

Reg. No. 1 - State Registrar Reg. No. 2. Date of Death **04/29/2011** 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month, Physician/ uller William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** rince bearse nton If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F Months Days Hours Min **Director** April 30 Ashinoton Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No \mathcal{U}_{L} 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 50 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be rances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4:11 f Health item 27 MD 5018 0745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition **Pate** 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Fort 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6 (elne Home Tels 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Presemma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner rdopul miny Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death signed by the a d be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 death? Physician: The 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) DOD 65207 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kella IPUL 20735 Surrats Road 7503 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME, G915,5/23/2011, WS
State of Maryland / Department of Health and Mental Hygiene 2 [15788 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 April 29, Physician/ 7:33 PM Cheryl A. Gross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛱 F March 18, Country) Months Davs Hours Min DC 60 1951 Director 577-70-1294 Usual Residence of Decedent fshow 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No <u> Maryland | Prince</u> Geo<u>rg</u>e's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20716 17120 Russet Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11, Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of State Elementary/Seconday (0-12) College (1-4 or 5+) Public Affairs Officer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Shirley Snowden Henry T. Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, Maryland 20716 17120 Russet Drive Turhan P. Gross Sr. - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date May 6 2011 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 22. Name and Address of Facility Stewart Funeral Home, . Signature of Funeral Service Licenses ohn 1-Benning Road NE Washington, DC 4001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Due to (or as a consequent) Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) POMULE TO LY. TITLE CERTIFICATION APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed Cause (Disease or linjury the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Month Year Dav Pregnant at time of death signed by the al g Unknown ☐ Unknow P.0. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Attending Physician: The law page 2 has autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 🗆 No certificate nuemoni 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: မ X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death.

I Director: Aft
id in by the fur 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ò filled in 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I only one)

State

DHMH 17 Rev 7/2009

29b. Signature and

Name and address of person who completed

MAY 0 4 2011

cause of death (Item 23a) (Type, Print

1-8+

32. Registrans Signa

58510

29d. Date signed (Month, Day, Year)

11

04/29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 27, Day 2011 Physician/ 11:45 A M Dolores Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 □ M 2 👺 F Days (Month, Day, Year, Country) Maryland Min. Director 214-32-8294 79 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 🖾 Yes 2 🗌 No North Brentwood Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States **Examiner must** 20722 3912 Webster Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 2 No
If Yes, Give Black, White, etc. "natural", or i 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🔀 No Specify: 3 Nidowed 4 Divorced Completed Year or Dates <u>American</u> traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than * College (1-4 or 5+) Elementary/Seconday (0-12) Home Care Self-Employed 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saul O. Lewis Sr. Rosie Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 9036 Watchlight Court Columbia, Maryland JoAnne Keini - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mary Land
Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 2011 21. Signature of Fulheral Service Lice Kee 22. Name and Address of Facility Stewart Funeral Home, other 4001 Benning Road NE Washington, DC 20019 23a. Cart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ph sician/ Possibl Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death.
Funeral Director: After this certificate has been signeted filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? benther performed? Yes 2 No 1 ☐ Yes 2 ☐ No eferred to medical 25. Was case Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕅 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and although certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-29-11 1745660 tem 23a) (Type, Print) Fex LN, 124 address of person who completed cause of death ALLANT 3001 31. Date filed (Month, Day, Year)

MAY 0 4 2011 32. Registra s Signat State Registrar

State of Maryland / Department of Health and Mental Hygiené-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25, 2011 **Physician** Rosie Greene Veronica 4:25 PM/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Prince George's 6413 Adak Street Capitol Heights Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) DC **Funeral** Days 0342421933 577-44-0940 1 □ M 2 🔀 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Yes 2 No MD Prince George's Capitol Heights Director death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 6413 Adak Street 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examines 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Black ģ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Washington Matthews Rosie Olivia Herbert 19a. Informant's Name/Relationship (Type. Print)
Jalinda Huff/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16000 Tanyard Road, Upper Marlboro, MD 20772 Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If It any Injury or o 05/02/2011 Lincoln Memorial Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 5538 Marlboro Pike Forestville, MD 20747 23a. Part Effer the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Ovarian Cancer **⊀Medical** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph for use as t IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 24 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) 1 ☐ Yes 2 [X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

State Registrar Sara L. Horton, M.D. 31. Date filed (Month, Day, Year)
MAY 0 3 2011

30. Name and address of person whicompleted cause of death (Item 23a) (Type, Print)
Sara L. Horton, M.D. 2041 Georgia Ave, NW, Washington, DC 20060 Cancer 32. Registrar's Si

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Please Type or Print in Black Indelible Into Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 Physician/ Month May 07, 201 Year Elizabeth Gephart 4:35M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 28, 1913 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 DM 2 N F Months Days Hours **Director** 216-05-5852 98 Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Lonaconing Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 57 Jackson Street 21539 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates. 77 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 **Janitor** Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Holmes Matilda McElvie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Holmes 213 East Street, Frostburg, Maryland, 21532 If item 2 or other t 20a. Method of Disposition Date May 11, 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Frostburg Memorial Park Frostburg, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CHRUNIC Lung Disease disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to (bride a consequence ory: if any, leading to immediate cause. Enter Underlying signed by the attending physician and I be detached for use as the burial-transit Cause (Disease or iinjury that initiated events certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown •• ure runeral ulrector: After this certificate has been si completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The Within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 🗹 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 305% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidhu 925 Cumberland 20 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 25,27 per me 915,5-17-11 yt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month) S Physician/ 2011 Viola Alice Grove 505 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS-Regional medical Allegany umberlano center 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month Day, Year) 4/01/1932 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex **Funeral** Min. 217-28-9032 79 Months Hours **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Mineral WV Keyser 1 🗌 Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 26726 Rt. 6 Box 6918 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?, 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Pulp & Paper Mill Paper Tester Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee E. Miller Ada M. Trezise မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 6, Box 6918, Keyser, WV 26726 19a. Informant's Name/Relationship (Type, Print) Charles Grove/husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/13/11 Keyser, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. Harold Dear 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ oncerone disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at er death.

To the Funeral Drector After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nonetient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 KNatural 2 KAccident 5 Pending P 36 1 Yes 2 No Investigation 6 Could not be 3 Suicide He of Hury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

NAWEWS WYSEW 4 Homicide DOCTION'S ODSICE Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Wedical Examiner: On the pasis of examination and/or investigation, in my operation of the cause only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 12500 Willow brook State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brent Harding He	1	For State	tate of	Maryla		epartment o Certificate o		and N	Mental H	_	Reg. No	20	Production of	1579
Physiciar Medical Examine	1/	1. Decedent's Name (First, Midd Brent Harding		NER,	Sr.					2. Date of De Month May 1, 2	Day	Year	3	Time of Death 1255 hrs
j		4a. Facility Name (if not instituti Meritus Medical Cent		reet and nu	mber)		4b. City, Town Hagersto		ation of Death			c. County of I Washingto		
Funeral Director	- 1	5. Social Security Number 220-64-1217	6. Sex	2F	7. Age (In) 56	yrs. last birthday) Yrs		\rightarrow	f Under 24Hrs Hours Min.			Í F	oreign	olace (State or try)Maryland
j es	,	Usual Residence of Decedent 10a. State 10b. County Maryland Wash	ningt	on	10c.	City, Town or Loca			•				- 1	Od. Inside City Limits Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	ᄓᆫ	10e. Street and Number 9612 Morning			L e	Hagerstown 10f. Zip Code 21740					10g. Citizen of What Co. USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers than "matural", or items 23a or 28a-f sho important. If item 77 is marked other than "matural", or other traumatic event, the Medical Examiner must be notified at once	= L	11. Marital Status 1 Never Married 2 X N	larried 1	2. Was Dec	edent Ever	lf \	as Decedent of es, specify Cu	ban, Me	exican, Puerto		0-	White, e	etc.	n Indian, Black, JHITE
6 72 hours after an "natural"	completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or ecify only h	es, Give Yeer Dates: nighest grad College (1	e complete	ed) 16a. Deceder during n	Yes 2 X nt's Usual Occu lost of working	pation ((Give kind of v			Specify: Kind of Busin	ess/Ind	ustry
21215-0036 Juld be filed within 7 Mental Hygiene ic event, the Medica		11 17. Father's Name (First, Middle	, Last)	0			carpent		Nother's Name	(First, Middle,			tia	l carpentr
2121 ould be fil Mental H marked	0 0	Harry Harding	-			19b. Mailin	g Address (S			izabeth			State, Z	ip Code)
e, MD and 2 sho lealth and item 27 is traumati	-	Kathryn Hepner				20b. Place of Dispos	sition (Name of			ane, Ha		stown,		• 21740 wn, State
Baltimore, semit. Pages 1 an Department of He Important: If ite		1 X Burial 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:		om State	Boonsboro				6/11				Maryland
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Physician /Medical xaminer		failure. List only one cause failure fause (Final disease or condition resulting in death)	on each I		noxide T	oxicity	пе тоде ог дуг —————	ng, sucr	n as cardiac o	r respiratory ar	rest, sn	ock, or neart		Approximate Interval Between Onset and Death
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60, tte be executed hysician and e burial - transit		UNPENDED F FEMALE:		MENDED 23c. If yes, o	utcome of	pregnancy					23	3d. Date of de	livery	
the death certificate the death certificate by the attending physched for use as the beneficial of the definition of the	2	3b. Was decedent pregnant in t past 12 months?	he 1	l Live bi	rth ant at time o	2 Fe	ital death her (Specify)	3 <u>E</u>	ctopic pregna	ncy	20	Month	Day	Year
P.O. B es that the d igned by the detached	2	art II. Other significant condi				not resulting in the I	underlying caus	se given	in Part I.			use contribu		cause of death?
Division of Vital Records, P.O. Box 6876(rat or Attending Physician: The law requires that the death certificate all Director: After this certificate has been signed by the attending phys led in by the funeral director, page 2 should be detached for use as the beatification. To Be Committed by Directorian Marketician Marketican Marke	Complete											prio dea	r to com	sy findings available pletion of cause of
Vital ysician:		25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hosp	oital: 1 Ir	patient 2	2 ✓ ER/Outpatient		Othe	Death (Check of	only one) g Home 5	Reside	ence 6 (ther:	
	- -	27. Manner of Death 1 Natural 5 Pen	ding stigation	28a. Date of FOUND: May 1, 2	Day,Year)	28b. Time of I FOUND: 1205 hrs	· · _	njury at Yes	2 No	28d. Describe Subject inh on vehicle i	aled c	carbon mo		e while working
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		one) 2 Medical Exa	miner:On and		f examinati	wledge, death occur ion and/or investiga								ause(s)
	2	9b. Signature and title of certification of the signature and title of the signature an	er Ekst E	6.1	MD		29c. Lice O.	ense nu C,M.E				Date signed y 2, 2011	(Month,	Day, Year)
3	3	0. Name and address of person Melissa Brassell, MD		pleted caus stant Med			/. Baltimore	Stree	et, Baltimoi	re, MD 212	23			
Stat Registra	~	1. Date filed (Morn), Pay, Yard	100	32. F	gistrar's Sig	gnature							-	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ :14 am Doris Kinard Holland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Plata a If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🔀 F Months Min. July 8,1918 579-14-4224 92 **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Wesley Drive, Unit 225 20646 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Baltimore, Maryland 21215-003 3 X Widowed 4 □ Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Case Worker State Govt. Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Moore Sadie Frances Archer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Gilda Derricote/ Daughter 7505 Lanham Lane, Fort Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If its
any injury or of 1 Burial 2 K Cremation 3 Removal from State Brinsfield-Echols Crem. 5/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall,MD 21. Signature f Funeral Service Licensee 22 AREHART ECHOL'S FUNERAL HOME, P.A. 0-St. Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ OND Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical the as IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of deliver Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Pregnant at time of death 5 Other (specify) the should be detached Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause o eath? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 24 hours after death. Funeral Director: After this certificate Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ ER/Outpatient 3 DOA 1 Depatient 2 🗆 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation the Suicide 6
Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier prtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b, Signature and title of certifier 29c. License number n (Item 23a) (Type, Print) Date filed \ Nonth, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 per ar Manylands Papertment of Health and Mental Hygiene State Registrar Amend #1pfh5/9/2011ccdohrb

Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death Byron Physician/ April ື2011 30 Bryon Ken Haskin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 25485 Point Lookout Road Leonardtown 8. Date of Birth
June 19, 1961 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours Mary Tand Director Yrs. 578-88-8485 49 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No St. Mary's Leonardtown <u>Marylandl</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25485 Point Lookout Road 20650 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Building Engineer <u>Maintenance</u> or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myra Elizabeth Limerick <u>Bob Lewis Haskin</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 <u> William H</u>askin/ Brother 6480 Sunnyside Drive, Bryantown, Maryland 20617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Trinity Mem. Gardens May 4, 2011 Waldorf, Maryland</u> Service Lice 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Fune 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. liac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) of): a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 3 Probably 4 Dunknown 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law autopsy performed? prior to completion of cause of 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00 31. Date filed (Month, Day, State 32. Redistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Theodore C. Haaser 230AM **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 ■ M 2 □ F Days Hours Feb. 9, Year 1924 Director 6 87 Ohio Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mitchellville 1 Yes 2X No MD Prince George's 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral USA **Examiner must** 20721 10450 Lottsford Rd., #2006 items death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates. WWII traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FBI Agent Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ည Robert Haaser 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 Mitchellville, 10450 Lottsford Rd., #2006 Marion V. Haaser / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Metro Crematory 4/29/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Pag. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy ic in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performe certificate 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Minpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 Matir 31. Date filed (Month, Day, MAY 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:35P^M **JESSE** HOUSER DEAN April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6001 Road, Apt. # 307 Temple Prince George's Fisher Hills 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8 Date of Birth Month, Day, Funeral Days Hours Min. 1 🕱 M 2 🗆 F Washington. 70 Director Sept Ĩ940 578-54-6289 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events once. 10c. City, Town or Location 10a. State 10h. County 10d Inside City Limits Director Maryland Prince George's Temple Hills 1
¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 USA Funeral 6001 Fisher Road, Apt.# 307 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Cab Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dean John Garnett Constance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Indian Head Hwy.. #C2. Ft. Washington.MD <u> Christopher D. Houser (Son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 05/05/2011 Riverdale Park Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Therosel disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Vear Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examina? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) Hospital 24 hours Medical 1 📃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day

of person who completed cause of death (Item 23a) (Type, Print)

VOID

CERTIFICATE

2011-15798

SEE

CERTIFICATE

2011-15602

Sent 5.23-11 WS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20^{Yea} Jean Catherine Hobday May 7:15 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 10002 McKinley Drive Hancock 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min (Month, Day, Year) 2/02/1928 82 Yrs Director WV 236-40-8225 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 3a or 28a-f st t be notified a 1 √ Yes 2 □ No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a "natural", or items 23: USA 10002 McKinley Drive 21750 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Trailer College (1-4 or 5+) Sub Assembly Lead Person Manufacture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cordie Elizabeth Newbraugh Robert Milford Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2960 Luther Michael Rd.Berkeley Springs, WV 25411 <u>Diane E. Miller/Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkhead Cemetery 05/12/2011 Big Pool, MD 21. Signature of Furreral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pulmonary Embolism Medical Due to (or as a consequence of) Examiner Osteoporosis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit executed C. Diff Colitis that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Hospital or Attending Physician: The law requires that the death certificate be £24 hours after death.

Funeral Director: After this certificate has been signed by the attending above. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day Year n signed by the a Id be detached fo g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to trie cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar Joseph Hashem, M.D. 226 Gayle Drive Berkeley Springs, WV 25411

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 9:00 M 00950r Mar 201 Medical 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Ba Himore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours Min. Director 4-13-47 Usual Residence of Decedent . Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 0e, Street and Number 10g. Citizen of What Country? Funeral 1.5.A filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Neyer Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩idowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Department of Health and Ment-Important: If item 27 is marked any injury or cat. 2 AND ZELLER KITA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY CARICO altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ▶ Burial 12 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ARHILL CEMETERY BROOKLYNBARK, MO. 5-16-2011 22. Name and Address of Facility Daugherty Funeral Home PASADENA, MD. 21122 23a. Part 1. Enter the di case, or con shock, or heart failure. List only caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line Immediate Cause (Final Ph_sician/ Biliary disease or condition resulting in death) leal Medical Due to (or as a consequence of) Examiner -PSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 0 the Unknown by s been signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? nolecystitis 24a. Was an has e 2 page performed' this certificate diabetes 2 🗌 No 1 🗌 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No 2 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May Kes 003 10 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRIESHOBER MP UNIVERSITY OF MARYLAND MEDICAL CENTER 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month B 161 O Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deal 4c. County of Death 0 Social Security Number 6. Sex Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min 579-46-2693 Director 74 Usual Residence of Decedent ural", or items 23a or 28a-f show I Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES 1 Yes 2 No WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3876 OLD WASHINGTON ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE "natural" 3 Widowed 4X Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HAYMOND CAREY FULKS LULA M. MOLLOHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is DANIEL HAMILTON 8768 DOVE DRIVE BEL ALTON, MD 20611 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of MAY Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 12,2011 ALEXANDRIA, 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licen-Sant £2 M00641 5635 WASHINGTON AVE. , LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARDIA Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying g physician and ss the burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month ate has been signed by the atter page 2 should be detached for 9 Unknown 9 Unknown Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co wute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings wailable prior to completion of cause of death?

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Yes 2 No 24a. Was an autopsy performed After this certificate Yes 2 4 25. Was case referred to predical the funeral director. Be 26. Place of Death (Check only one) Hospital Other: 1 Tes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Washington Adventist Hospital Kevin Lawrence, M.D., 31. Date filed (Month, Da State Registrar's Signa Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Mary Elizabeth JONES Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 8. Date of Birth Oct. 25 1942 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours 1 🗆 M 2 💢 F Maryland **Director** 213-40-6755 68 Usual Residence of Decedent show 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 ☐ Yes 2 🛣 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1151 Linwood Road 21740 should be filed within 72 hours after death vand Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ŏ þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural". Completed 3 Widowed 4 Divorced Year or Dates other than "naturent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Family Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o 27 is marked or traumatic eve ပ Robert Huyett Shank Thelma M. Spickler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary M. Jones - Husband 1151 Linwood Road, Hagerstown, Maryland 21740 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/6/2011 Hagerstown, Maryland Signature of Juneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atho glerosios 4 stimic Cardio Jascular depend disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Be Completed by Physician/Medical Examiner Use to for as a consequence of) if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown perlipids 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No ျ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R06412 reise CRINF

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-03316 Jenine Cora Jul	iuss	Ola	e or Print i te of Maryl	and / Dep	artment o	f Health an	e All Co d Mental	pies Are L Hygiene	egibl	e.	1 1500
Dhyaio	/	1- For State Registrar 1. Decedent's Name (First, Middle,	l oot\	Ce	ertificate o	f Death			Reg. No		1 1000
Physici Medical Exam		Jenine Cora Jul	,					2. Date of D Month May 1, 2	Day	Year	3. Time of Death 0941 hrs
		4a. Facility Name (if not institution,	_	umber)		4b. City, Town, or			4	c. County of D	
Funeral		Meritus Medical Center 5. Social Security Number 6	. Sex	7. Age (In yrs.	lost hirthday)	Hagerstown		um To District		Washingto	
Director		157-46-1218	1 M 2 X F	58	Yrs	Months Day		Min. Nov.	18.1	.952 Fo	Birthplace (State or preignew Jersey Country)
,		Usual Residence of Decedent 10a. State 10b. County									
d how any		1	gton cou		, Town or Local						10d. Inside City Limit
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	90011 000	110)		10f. Zip Code			10g. Cit	izen of What C	
h the N 3a or 3		925 Beechwood	Dr.			21742				U.S.A.	
ath wit items 2	Funeral	11. Marital Status 1 Never Married 2 Marr		cedent Ever in U		s Decedent of His es, specify Cuban			No-	14. Race - Ar White, etc	nerican Indian, Black,
ufter de	by Fu		1 Yes ced If Yes, Give Yea	2 X No	1	Yes 2 X No	specify:			Specify:	White
hours a	ed be	15. Decedent's Education (Specific	only highest grad			t's Usual Occupat			16b. I	Kind of Busine	ss/Industry
356 thin 72 re. than edical	Completed	Elementary/Secondary (0-12)	College (1	I-4 or 5+)		1 Secret			Re	search	Center
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-7 sho or other traumatic event, the Medical Examiner must be notified at once.	S	17. Father's Name (First, Middle, La	ast)				18.Mother's Na	me (First, Middle	, Maiden	Surname)	
2121 ald be f Mental marke event,	To Be	John Juliussen 19a. Informant's Name/Relationship	(Type Print)		10h Mailine	Address (Street		David J			
MD 12 shorth and 27 is umatic		Heather Juliuss	en-Steve	nson	925	Beechwoo	d Dr. H	lagers to	wn,	MD 2174	ate, Zip Code) 42
or Fe, and of Heal of		20a. Method of Disposition 1 Burial 2 X Cremation		P20b.	Place of Dispos crematory or oth	tion (Name of cen		Date	20c.	Location - City	or Town, State
Baltimore, permit. Pages 1 and Department of Heal Important: If iten njury or other tra		4 Donation 5 Other Spec	ify:	Sm		g Cremat		-3 - 2011		ithsbu	
Baltimore, MD 2 permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatic c.		21. Signature of Funeral Service Lic	censee	1.7		ame and Address 31 Easte:		Douglas North	A. F	iery Fu	uneral Home n, MD 21742
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	mplications that ca	aused the death	. Do not enter th	e mode of dying,	such as cardia	c or respiratory a	rrest, sho	ck, or heart	Approximate Interva Between Onset and
£xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Probable P	ulmonary Th		olism	<u></u>				Death
			b	consequence o	··):						
	xaminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	f):						
ed nsit	Exam	events resulting in death) Last	Due to (or as a	consequence o	f):						U
executed an and al - transi	ical	UNPENDED	d								
760, cate be physic	Med	IF FEMALE:	23c. If yes, c	outcome of preg	nancy				23d	l. Date of deliv	ery
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	3b. Was decedent pregnant in the past 12 months?		irth ant at time of de	ath	aldeath 3 er <i>(Specify)</i>	Ectopic preg	nancy		Month	Day Year
BO) he deatl	hysi	1 Yes 2 No 9 V Unknow	9 UNKNO								
, P.O. Box 68760, signed by the attending physician and be detached for use as the burial - tran	ক্র	Part II. Other significant condition ruptured vertebral disc s					ven in Part I.				to the cause of death?
rds, require been sig	Completed		Tatao poot oa	- groun ropun	, 0000, 11	pertension		24a. Was		24b. Were	autopsy findings available
he law ate has	팂	· · · · · · · · · · · · · · · · · · ·		 -					ormed?	death1	
Vital Records ysician: The law requii his certificate has been i	Be C	25. Was case referred to medical examiner?					of Death (Chec		2 V No	1	Yes 2 No
Physic Physic er this	우	1 Yes 2 No	Hospital: 1 🗸 Ir	patient 2	ER/Outpatient 28b. Time of In	o Bon		sing Home 5	Resider		ier:
On of cading Phath.	tion	1 Natural 5 Pending	Apr 19, 2	Day Year)	UNKNOWN		es 2 V No		tured v		sc while lifting
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	2 Accident Investiga 3 Suicide 6 Could no	28e Place	of Injury - At ho	me, farm, street	, factory, office bu	ilding, etc.	heavy object 28f. Location (Street an	d Number or F	Rural Route Number, City
bou hou y fil		4 Homicide determin	ed (Specify)	Residence				or Town, 925 Beechwo			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ig	Check only Certifying Physi	cian: To the best	f examination ar	ge, death occurre nd/or investigation	ed at the time, date on, in my opinion, o	e and place, ar death occurred	nd due to the cau I at the time, date	se(s) and and plac	manner as stace, and due to	ated. the cause(s)
To with To com	ĕ Z	9b. Signature and title of certifier	and manner sta	ated		29c. License		_			lonth, Day, Year)
K		After brass	14.10)		O.C.M	I.E.		May	2, 2011	
1,	3	0. Name and address of person who	completed cause	of death (Item	23a)						

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Morm Av Y)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Melissa Brassell, MD

James Anthony Jackson, Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

 Type of the m Black machine mik. Ellouid All Copies Ale
State of Maryland / Department of Health and Mental Hygiene
otate of Maryand / Department of Mealth and Merital Hygietie

		1- For State Registrar Amer 1. Decedent's Nam	nd#20a	.20b.20cm	erfhc	Certific	ate of	<i>Peath</i>					Reg. N	о.			
Physic			(-,,			997 97				2	2. Date of D	eath			3. Time of Death	1
Medical Exam	iinei	OLD ADD LEVILLE										Month April 25,	Day 2011	y Year		0130 hrs	
		4a. Facility Name (i	if not institution	on, give street and n	ımber)		4	b. City, Tow	n, or Lo	ocation of	f Death		1	4c. County o	f Death		
		Fort Washir	ngton Hos _l	pital				Fort Wa	shing	iton				Prince G	eorge	's	
Funeral		5. Social Security N	Number	6. Sex	7. Age (Ir	n yrs. last bii	rthday)	If Under 1	Year	If Under	r 24Hrs.	8. Date of	Birth(MI	M/DD/YYYY)		hplace (State or	
Director		216-02-3360		1 X M 2 F	28		Yrs.	Months	Days	Hours	Min.	01/12/	1983		Foreig	n untry) MD	
		Usual Residence of		1 A W 2 1			115.					01/ 12/					
Any			10b. County		100	c. City, Town	or Location	n								10d. Inside City	imits
* .	١.	MD	CHARLE	7S		WALDORI										1 X Yes 2	
ylanc J-f sh	후	10e. Street and Nur				WILLIAM		101 7: 0			<u>.</u>						
Mar r 28s	Director	4709 B RO		PLACE				10f. Zip Coo						itizen of Wha			
5-0036 solution 72 hours after death with the Maryland Hygiene. Tygiene "matural", or items 23a or 28a-f shottle Medical Examiner must be notified at once.	0			HKI				2000	_				U	TIED 31	IAIL	,	
n wit	Funeral	11. Marital Status		12. Was Dec		er in U.S.		Decedent o					No-			an Indian, Black,	
deatl	.5	1 X Never Marrie	ed 2M	arried 1 Yes	V-	No	1116	s, specify Cu	ıban, iv	nexican,	Puerto K	ican, etc.)		White,	etc.		
after after ner	<u>\$</u>	3 Widowed	4 Div	orced If Yes, Give Yes	ar		1 📗	Yes 2. X ☐	No s	specify:				Specify:	В	LACK	
1215-0036 Id be filed within 72 hours afte Aental Hygiene. 22 Arked other than "antural", event, the Medical Examiner	5	15. Decedent's Ed	lucation (Spe	cify only highest gra	de complet		Decedent	s Usual Occ	upation	(Give ki	ind of wo	rk done	16b.	. Kind of Bus	iness/Ir	idustry	
72 h	Completed	Elementary/Seco	ndary (0-12)	College (I-4 or 5+)		_	st of working	liite. D	ONOLU	ise retire	a)					
O36 Iedichin	뭍	9				1	LABOR	ER						CONSTR	UCT	ION	
5-0 ed w other	S	17. Father's Name (First, Middle,	Last)					18.	.Mother's	Name (F	irst, Middle	, Maide	n Surname)			
	Be	JAMES AND	CHONY .	JACKSON, S	SR.				В	BARBA	ARA J	JEAN W	ARR	EN			
	P	19a. Informant's Na	me/Relations	hip (Type, Print)		19	b. Mailing	Address (S	treet a	nd Numb	er or Ru	ral Route N	umber,	City or Town	State,	Zip Code)	
MD d 2 sho tth and n 27 is		BARBARA C	J. WARI	REN/MOTHEI	₹									MD 20			
ore, MI ss 1 and 2 s of Health a If item 27		20a. Method of Disp				20b. Place	of Disposit	on (Name o				Date		. Location - (
ages I and 2 shount of Health and N				3 Removal fr			tory or othe		.		05/0	÷ /201	Cha	arlott	e Ha	11. MD	
timen trant		4 Donation 5				HERITA	AGE M	TUKIA	T C	Tri.	05/0	7/201	Ц 7	WALDUR	т,	MARYLANI	<i>'</i>
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other ti		21. Signature of Fur		JOHNSON MOO	10th		2/1	MATEURI MATEURI	FESS'M	TENT DO	THORN	ION FU	NERAI	L HOME,	P.A.	inc in	
	Н					dooth Dam								MARYLA			
Physician		failure. List onl	y one cause	complications that c on each line.	aused the	death. Do n	ot enter the	mode of dy	ing, su	ch as car	rdiac or re	espiratory a	rrest, si	nock, or hear	t	Approximate Int Between Onset	
Examiner	1	Immediate Cause (F		a. Multiple Gu	inshot V	Vounds										Death	
		or condition resultin	ig in death)	Due to (or as a	conseque	nce of):									1		
	Ļ	Sequentially list cor		b,		- 0											
	ine	if any, leading to im cause. Enter Under		Due to (or as a	conseque	nce or):											
	Examiner	(Disease or injury if events resulting in o		Due to (or as a	conseque	nce of):	_					-			- 1	-	
uted nd ransi		J	,	d.													
8760, ificate be executed g physician and s the burial - transi	n/Medical	UNPENDED		AMENDED													
8760, ifficate be ng physic as the bur	Je d	IF FEMALE:		23c. If yes,	outcome of	pregnancy							125	3d. Date of d	aliven		
m ' = ∞ ∞	3	23b. Was decedent p past 12 months?					Feta	death	3	Ectopic p	oregnanc	у	2	Month	-	y Year	
X 6 h cer tendi	양				ant at time			r (Specify)					1			•	
Box 687 ne death certific the attending properties of the proper	Physicia	1 Yes 2 N	o 9 Unk	nown 9 Unkno	wn												
s, P.O. irres that the signed by t		Part II. Other signif	icant conditi	ons contributing to	death but	not resulting	g in the un	derlying caus	se give	n in Part	I.	23e. Did	tobacco	use contrib	ute to th	e cause of death	?
P.O.	d by											1 🗌 Y	es 2	√ No 3	Proba	bly 4 Unkno	wn
ords w requii s been should	Completed											24a. Was	s an	24b. We	ere auto	psy findings avai	lable
cor law 1 has t	힏					<u>-</u>						auto	psy ormed?		or to co ath?	mpletion of cause	of
The The	હ											1 ✓ Yes			Yes	2 N	5
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referre examiner?	ed to medical	Henrital, con						-	heck onl	y one)					
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	흔	1 ✓ Yes 2	No	Hospital: 1 I	npatient	2 🗸 ER/0	utpatient	3 DOA	Oth	ner ₄ _ l	Nursing H	lome 5	Resid	ence 6	Other:		
Of ing Pl After unera		27. Manner of Death		28a. Date (Month) Apr 25,	of Injury Day Year)		Time of Inju	ıry 28c, I	njury a	t Work?		d. Describe		jury occurred			
Division tal or Attendiu ts after death.	읉	1 Natural 2 Accident	5 Pendi	ing Apr 25, 2 tigation	2011	0103	3 hrs	1	Yes	2 🗸 N	10	inlect su	Οί				
VIS r At ter d urect n by	ا≝	3 Suicide			of Injury -	At home, fa	arm, street,	factory, offic	e build	ling, etc.	28			and Number	or Rura	Route Number,	City
DIVI pital or ours afte reral Dir filled in	Certification:	4 V Homicide			Parking	g Lot					72	or Town, 5 Cady Dr	State) ive, Fo	rt Washing	ton, M	D	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death cert 24 hours after death. Funeral Director: After this certificate has been signed by the attendin tely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only 1	CertifyIng Ph	ysician: To the bes	t of my kno	wledge, dea	ath occurre	d at the time	. date a	and place	e, and du	e to the cau	ıse(s) aı	nd manner a	s stated	l.	
Division To the Hospital or Attention within 24 hours after death To the Funeral Director:	Medical			niner:On the basis of	f examinat												
7. ≥ 5. §	Σ	29b. Signature and t	itle of certifier	and manner st	a(eq			29c. Lice	ense nu	umber			29d.	Date signed	(Monti	h, Day, Year)	
		()_ N	1.					0	C.M.E	Ξ.				ril 25, 201			
		20. Name and addition		the constituted		/!! 00 :											
MRD		Name and addre Donna M. Vii					900 14	/. Baltimo	re St	reet D	Raltimo	re Min o	1223				
	70,5	31. Date filed (Month	·		gistrar's Si					icel, D	, and it is	C, IVID Z	1223				
Regist			(0 4 2	· · · · · · · · · · · · · · · · · · ·		A. M	borke										
			VIL	UII ALSTON		- 11											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4/2672011 Day Physician/ Bruce Ernest Johnson, Sr. 8:33 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign MD Country) Days 1 X M 2 🗆 F Hours 11/26/1944 Director 215-44-6989 66 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Rerlin 1¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11201 Adkins Rd. 21811 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Year or Dates. Army 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) security guard Security company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Linwood Johnson Edith Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heath a Important: If item 27 is any injury or other trau 9384 Green Branch Rd. Willards, MD 21874 <u>David E. Johnson (son)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet. Cem 5/2/2011 Hurlock, MD $^{22.\,\text{Name and Address of Facility}}$ The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the direase, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ elimply DAY disease or condition Medical resulting in death) Due to (or as a con uence of) **Examiner** seemply ARTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last g physician and as the burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. | signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1X Natural 5 \square Pending iniury neral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direct 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o certifi 29c. License number 29d. Date signed (Month. Day, Year) D53551 April 26,2011 person who completed cause of death (Item 23a) (Type, Print) James Todd 100 E. Carroll St. Salisbury, MD 21801 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Raymond Johnson Junious April 28, 2011 5:17 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Ft. Washington Hospital Prince George's Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth

July 27,1932 Social Security Number 225-34-8038 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
78 Yrs. 6. Sex Months Days Hours ^cvirginia 1 Ϊ M 2 🗆 F Usual Residence of Decedent 10a. State MD • 10b.County Prince George 10c. City, Town or Location Ft. Was 10d. Inside City Limits Washington 1 ☐Yes 2 XNo Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8011 Vernon Drive 20744 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. NYes 2 No Yes, Give 1953 – 56 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XX No SpecifBlack <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moody Family Cem May 5,2011

the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

18. Mother's Name (First, Middle, Maiden Surname)
Maggie Johnson

8011 Vernon Dr., Ft. Washington, Md.20744

22 Georgia Ave., NW, Wash, DC 20011

20c. Location - City or Town, State

Bumpass, Va.

23d. Date of delivery

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Approximate Interval Between Onset and Death

Year

10

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "named other than "named". **Physician** /Medical Examiner

Be

17. Father's Name (First, Middle, Last)
John Jones

20a. Method of Disposition

23a, Part1

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Ligensee

Enter the disease

shock, or heart failure.

Gloria Desper (Wife)

MO126

lications that cause

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Burial 2 Cremation 3 Removal from State

Funeral

Director

attending physician and for use as the burial-transit sate has been signed by the page 2 should be detached certificate funeral director. this Director:

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Factor of the second of the se Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 24a. Was an autopsy performe 1∐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 [Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Ali Mirza-Alikhani, MD; Ft. Washington Medical 1171 <u>Livingston Registrals signatur</u> ashington Md. 20744

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 2^{Day} 20^{11} 10:21 AM Patricia L. Krauss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Rising Sun 208 Crothers Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Aarch 17, 9. Birthplace (State or Foreign Novethr) East Mary Land Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Hours Director Vrs 1940 214**-**40**-35**85 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Rising Sun Maryland Ceci1 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21911 United States 208 Crothers Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black, White, etc ģ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 XNo within 72 hours after Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Marshall Williams Tracie Leone Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21911 Kenneth M. Krauss / Husband 208 Crothers Road, Rising Sun, Maryland Baltimore, 20b. Place of Disposition (Name of Bib emeters commetted of Bib emeters)
Baptist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 2,2011 Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 as Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Immediate Cause (Final Onset and Death Physician, Hdenocurcinone 7 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE use ? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law autopsy performed? Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year, D.0044373 2011 28 ひレ and address of person who co ppleted cause of death (Item 23a) (Type, Print) Joseph Weidner, ₹01 Colonial Way, Rising Sun, Maryland 21911 31. Date filed (Month, Day, Year) **MAY 0 4 2011** State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2040M Kitchen Lucille Avis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 7, **Funeral** 7. Age (In yrs. last birthday, 1 🗆 M 2 🕱 F Hours Min 85 Director 216-22-8391 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 □ No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Saint Paul Street 21713 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. Hygiene. \$ 1 Never Married 2 X Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes ∠ If Yes, Give 1 ☐ Yes 2X No Specify: 3 Divorced Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) injury or other traumatic event, the should be filed with and Mental Hygien 7 is marked other tl General Contractor Executive Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myrtle Eva Knode Guy Wilbur Smith 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 Bruce M. Kitchen/Husband 101 Saint Paul Street Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 05-07-2011 Boonsboro, Maryland 21. Signatur of Fund Service Lio-1 ee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA any 21713 7606 Old National Pike Boonsboro, MD Enter the disease, or complicator heart failure. List only one complete the complet ons the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock Interval Retween Immediate Cause (Final Onset and Death Physician/ Hemonha aye disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 N 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, seath section and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 20311 Lappons Rd Boursboro Mg 25713 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 MD ar all 31. Date filed (Month 32 egistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Mont Physician/ Kathleen Lowman KEGARISE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 328 South Mont Valla Avenue Hagerstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours June 25, 1940 Country) Maryland 70 219-34-5227 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 er than "natural", or items 23a or the Medical Examiner must be Funeral USA 21740 328 South Mont Valla Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 1 and 2 should be filed within 7, f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) nursing assistant nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Robert Clarence Baker Clara Barbara Lowman injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayetta Spigler - daughter 1060-H Noland Dr., Court 7, Hagerstown, Md. 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 Donation 5 Other (Specify) 5/5/11 Rose Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME Wilson Blvd., Hagerstown, Md. 21740 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Buch as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause o Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** MCNOWI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Other (specify) Day Pregnant at time of death signed by the aid be detached for 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Probably 4 Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has death?
1 Yes 2 No this certificate Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending 1 Natural Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature/ar 29d. Date signed (Month, 30. Name and address of Wadn Noble Trifete Tals A Mile th Right 31 (150e, Print)

DHMH 17 Rev 7/2009

State Registrar REYNOLDS

M. WALNUT STREET

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 April **Physician** 29, Martin Vinton Kersey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Abbey Monor Assisted Living LaPlata If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days Hours 1**X** M 2□ F Yrs. Jan. 1917 Director 94 315-16-7502 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examination August the mailting at 10b. County 10a. State 10c. City. Town or Location Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 Kentucky Avenue Funeral 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give 1937 – Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: White 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Electrical Engineer</u> Dept. of Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဨ Curtis Rov Kersev Icie May Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kersey/ Son 8600 Kentucky Ave. LaPlata, Maryland 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets' Cem. May 10, 2011 Cheltenham, MD. 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Huntt Funeral Home moll9@|3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause up each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) Division of Vital Records, P.O. □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ector, page 2 should be 1 Tes 24a. Was an autopsy performed? 1 TYes 25. Was case referred to medical Be

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23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2ĂNo 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

7:57 P M

Birthplace (State or Foreign
Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Montana

7(B]+

State Registrar

Medical Certification: To

the

filled in by

completely

examiner?

27. Manner of Death

1. Hatural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

0

3 ☐ Suicide

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

32. Redistrar's Signature

park.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylar				lealth a			Reg. No	UII	158	• •
*	Physici	an	Decedent's Name (First, Middle, La								2. Date of De Month	Da	y Year	3. Time o	
· M	/Medic	cal	Stephen John Kova 4a. Facility Name (If not institution, given				4b Cit	Y Town o	r Location	of Death	April		. County of Deatl	3:40) A M
A.	Examir	ier	Prince George's H		nter			verly		OI DOG(II			rince Ge		•
ì	Funeral	~	5. Social Security Number 6. S	Sex 7. Ag		iast birthday)	If Und	er 1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, D.	rth	9. Birth	nplace (State untry)	
18.	Director		390-10-2710	1 🖾 M 2 🗆 F	86	Yrs.	Month	s Days	Hours	Min.	Aug.	3,]	1924 Cha	ttaroy	, WV
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside (City Limits
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	r 28a	rec	10e. Street and Number	300180			10f. Z	ip Code				10g. Cit	tizen of What Co	untry?	
	th with	ai D	5813 Eastpine Drive	e			20	737					US	A	
	ema FILE	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Dec	edent of H	ispanic Ori	igin? (Spe	city Yes or Ni Rican, etc.)	D-	14. Race - Ame Black, White		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 X Yes 2 1		II		2 X No	Specify:				Specify:		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. d other then "natural", or itema 23s or 28s-f show event, the Medical Exertion could be coulded at	ed b	15. Decedent's E	Year or Dates:	1943-		dent's Us	ual Occup	ation			16b. K	ind of Business/	White	
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g	be filed vial Hygie d other i	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
<u>ya</u>	2 should be and Mental I is marked o	٩	John Kovash			1				-	n Havr				
Ma	O1 (0 -= 08		19a. Informant's Name/Relationship (John W. Kovash /										or Town, State, Z	(ip Code)	
<u>က်</u>	1 and Health iem 27 other tr		20a. Method of Disposition	3011	20b. F	Place of Disponentery, crea					verdare ate		D 20737 ocation - City or	Town, State	
ομ	ages ant of it: if it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr			cemetery, cre Veter			1	5/10	/11		ltenham,		land
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or othar once.		21. Signature of Funeral Service Lice		FID				ss of Facili		/11		39 Balti		
m	ed in a		Kozanda R	An Rogers		Ga	sch	s Fu	neral	Home	e, P.A.		attsvill		
3760,	Physician /Medical was percented the prival-transit physician and physician and physician are percented to the prival from the	icai Examiner	23a. Part Enter the disease, or com shock, or heart failure. List only timmediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis Due to (or as b. Pneumo Due to (or as c. COPD Due to (or as	ne. S a conseq onia a conseq	juence of):	er (rie in	ode of dym	g, such as	cardiac of	төэрлагогу а	arrest,		Approxima Interval Be Onset and	tween
P.O. Box 687	t the death certific by the attending p ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	il déath 3[leath 5[Other (23d. Date of dei Month	Day	Year
Records,	w requires that been signed I should be det	by	Part II. Other significant conditions of	contributing to death b	ut not res	sulting in the u	nderlying	cause giv	en in Part i				use contribute to		
	The law rate has be page 2 sh	Completed									24a. Was auto perf 1 \(\text{Yes}	psy ormed?	death?	completion of	s available cause of
of Vital	Physician: T r this certificat ral director, pa	Be (25. Was case relerred to medical examiner?							e of Death	(Check only				
5	Physic this co	မ	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatie		ER/Outpatier			4 🗆 191			_	6 □Other (Spe	cify)	
ב	er fe	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	t M	28c. Injun Wor			8d. Describe	how inju	ry occurred		
DIVISION	or Atten fter deat director: in by the	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	000 Diagoni lai	ury - At h	ome, larm, sti			Yes 2 🗌		28f. Location City or To		nd Number or Ru e)	ural Route Nu	mber,
	Full fely	Medical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examina	wledge, deat ition and/or in	h occurre vestigation	d at the tin	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time	cause(s , date an	s) and manner as d place, and due	stated. to the cause	(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	2.5			2	9c. Licens	e number			29d. Da	ate signed (Mont	h, Day, Year)	
F			1 Hell	Mu	X			1)2	75	ファ		04	4/30/1	/	
ć	2+1		30. Name and address of person who												
_			Ophnell A. Cumber	batch, 841	6 Ce	ntral	Aver	ue,]	Lando	ver,	MD 207	85_			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2011	JZ. Hegetra	A S S The	Jes J									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04 - 26 - 2011 MARTHA WINONA COVINGTON KNIGHT 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7237-A G Street Seat Pleasant Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 07-07-1 1 🗆 M 2 🟋 F Days Months Hours Min. 55 **Director** 577-74-2201 DC Usual Residence of Decedent Show 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 □ No Prince George' Seat Pleasant 10e, Street and Number P 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7237-A G Street USA 20743 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: Black "natural" 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Probation Assistant Federal Government Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Willie B. Stubbs James W. Covington should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Angela Knight/daughter 7237-A G Street, Seat Pleasant, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of P Important: If ite any injury or ott once. 1 Donation 2 Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) 04 - 29 - 2011Riverdale Crem. Riverdale, MD 21. Signature Funeral Service Licenses 20746 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, 23a. Pa 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 years Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transil Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 2 🗆 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 🕅 Residence 6 - Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Division of Vital Records,

of the state of th within 2

29a. Certifier

only one) 29b. Signature and title of

31. Date filed (Month, Day, Yea

State Registrar

Mahruku Hussain, MD, 1221 Mercvantile Lane, Largo, MD 20774 32. Registra 's Signature MAY 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD D0060050

29d. Date signed (Month, Day, Year)

04-28-2011

11-03424 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Margaret A. Kelly State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar nt's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Margaret Ann Kelly Month Medical Examiner 1211 hrs May 6, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7, Age (In vrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Min Months Dav Director 134-30-7918 71 Sep 4, 1939 CountryMA 1 M Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits MD Allegany Cumberland 1 X Yes 2 No or 28a-f show , or items 23a or 28a-f shor must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Meadows Street 21502 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes white If Yes, Give Year or Dates: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours afte.
Department of Health and Mental Hygies within 12 hours afte.
Important: If item 27 is marked other than "natural", injury or other traumatic event that the contract of t 3 Widowed 4 Divorced 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Richard Martin Carmen (Petersen) Martin 19a. Informant's Name/Relationship (Type, Print)
Peter Kelly Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cede) 21502 husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State crematory or other place) 1 Burial Scarpelli Funeral Home, P.A 5/9/2011 MD Cresaptown Donation 5 Other Specify. 22. Name and Address of Facility Scarpelli Funeral Home, PA . Signature of Funeral Servide Ligensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vascular Injury due to Transbronchial Biopsy of lung Physician Approximate Interval Setween Onset and /Medical Death a for Metastatic lung Carcinoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f, per me, g919 9-15-11 sm X UNPENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of performed death? ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Approximately subject underwent biopsy 1 Natural 5 Pending 1 Yes 2 X No fd 5-6-11 11:30 am procedure 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town State) Western Maryland Health System 1/500 Willowbrook Rd . SE Suicide 6 Could not be (Specify) Hospital Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DOME May 7, 2011 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jake William Kesecker April 23^{Pay} 2011 ear 6:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 723-07-9675 SeB. 1927 West Virginia 83 Director Usual Residence of Decedent shov or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1384 Salem Ave. 21740 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Welder Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert S. Kesecker Mary S. McJilton Kesecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. William Resecker-son 1384 Salem Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/27/2011 Hagerstown, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on past line. Immediate Cause (Final MONIA Physician/ disease or condition Medical resulting in death) (or as a consequence of): Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 Yes 2 No peen a Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 Xunpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Settifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaty of certifier who completed cause of 30. Name and address of 0-H-0 MET

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav Physician/ Month 1105 PM Elizabeth Leasure may Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 8. Date of Birth 9. Birthplace (State or Fon Country) 1923 Pennsylvania If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, 1 M 2 X F Days Director 193-14-6781 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2X No MD Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18309 Hemlock Lane 21782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2X No 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lynn K. Fosnacht Myrtle M. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Leasure/ Daughter 711 Oak Hill Ave., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗶 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Rest Haven Cemetery 5/5/2011 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5.Me 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cerebrovasc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year Pregnant at time of death Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform certificate Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Funeral D Medica 29a. Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.D. dress of person who completed cause of death (Item 23a) (Type, Print) 3 12821 Oak Hill 21742 Man gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Day Bernice Maxine Langford Apri] 29 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) Funeral 1 □ M 2**X** F Months Days Hours Min (Month, Day, Year) 01/20/1926 Yrs. **Director** 579-20-6436 85 Wash.D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits must be notified at Director Md. 1X Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 118 Carlisle Drive 20904 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🕱 No Specify Specify: American 3 → Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) D.C. Government other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier Supervisor Visiting Nurses Assoc. 2 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Powell ൧ Erma Mae Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i Leon C. Langford/Son 118 Carlisle Dr., Silver Spring, Maryland 20904 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 05/06/11 Lincoln Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Henry S. Washington & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses Janu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗆 Yes 2 🏝 No Hospital ျ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Matural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number 29d. Datte signed (Month. Day, Year) 20

DHMH 17 Rev 7/2009

State Registrar 7300 Van Dusen Road, Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arlene Allen,M.D.

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MATOnth 2011 03:21 AM CARA GENEVA MITCHEM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CECIL UNION HOSPITAL OF CECIL COUNTY ELKTON Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Hours Min (Month, Day, Year, N. 24. 1 83 **Director** VIRGINIA or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and tifter 87.5 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No CECIL MARYLAND ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2070 EAST OLD PHILADELPHIA ROAD 21921 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces?

1 Yes 2XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES BEACHER SEXTON ETHEL B. STROUPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW SEXTON / BROTHER 2066 EAST OLD PHILADELPHIA ROAD, ELKTON, MARYLAND 21921 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NORTHER XXXIII ON A HARPING COMETERY MAY 5,2011 NORTH EAST, MARYLAND 21. Sign 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, o shock, or heart failure. List, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Betweer Conset and Death Immediate Cause (Final Ph_sician/ Sepsis disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atherosolorotic 1 Yes 2 No 3 Probably 4 Unknown Completed Proumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsy performed? Yes 2 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending Investigation Accident 🔲 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Priysician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and titl of certifie 29d. Date signed (Month, Day, Year) 5.3.2011 0023322 Jackden SMD

Registrar

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eckton

Registrar's Signat

High ST

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Stephen, 1048 AM Michael 30 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Marylan o Medical 5. Social Security Number 7. Age (In yrs. last birthday)
67 Yrs. Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth WASHINGTON oreign 1 XM 2 - F Months Days Hours FEB. 23, Year 1944 Director D.C. 223-56-6839 Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND ANNE ARUNDEL 1 Yes 2X No DAVIDSONVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3879 QUEEN ANNE'S BRIDGE ROAD 21035 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 X Married 1 Yes 2 XNo If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HORTICULTURIST HORTICULTURE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ESSEX EARL MADRON JUNE MARJORIE MORRIS I and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ELIJAH MADRON/ SON 109 STATION LANE, GRASONVILLE, MARYLAND, 21638 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION MAY 3ate 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS A HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Physician/ Netabolic disease or condition aci Medical resulting in death) Due to (or as a consequence of) Examiner days tastic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and -trar resulting in death) Last Due to (or as a consequence of) the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? jo Month Day Year be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 Yes 2 No 5 Pending Accident completed filled in by the Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Apr, 30, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mackenzie Short South Greene Street, Baltimore, MD, 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month . 4:32 P 201 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner 60056 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№**M 2 🗆 F Months Days Hours (Month Day **Director** MAY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. ģ 1 X Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ▲ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) un14 Signature of Funeral Service Incensee 22. Name and Address of Facility breene Home Inc. FUNERM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. for use as the burial-transit and that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? Natural injury 5 Pending 1 Yes 2 No after death Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 0023888 e of death (Item 23a) (Type, Print) 30. Name and address of person who completed o 6900 6-EORGIA AVE NW 6 U

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2005 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Cheverly Social Security Number 6. Sox 14 ☐ M 2 ☐ F **Funeral** '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours Months Jan 29, Year) 27 Pennsylvania Director Yrs. 199-20-5409 84 Usual Residence of Deceden Show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Glenarden 10e, Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene. Important: If item 27 is marked other there any injury or other traumette. 3211 West Glenreed Court 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Black 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Cement Finisher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Mosley Margaret Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2015 Randolph Rd #101 Silver Spring, MD 20902 Regina Wiley - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Vet's Cemt. | May 3, 2011 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to for as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 No the 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl autopsy performed 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. May her of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? Investigation 2 No filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1/Cretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыется (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific ned (Month. ause of death (Item 23a) (Type, Print)

State

31. Date filed (Month. Day

MAY 0 3 2011

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Decoartment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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an/ cal	1. Decedent's Nam Wilma De	ne (First, Middle, L	.ast)					2. Date of De Month	eath	year	. 113 a. A. M	
ner	Prince G	eorge's	ive street and number) Hospital			4b. City, Town, Chever	or Location of Deat	h		c. County of De	eath George's	
	5. Social Security N 104-42-7		Sex 1 M 2 X F	ge (In yrs. I	ast birthday Yrs.	Months Days			ay, Year)		Birthplace (State or Foreig Country) Maica	
Director	Usual Residence o	10b. County	0 1		y, Town or	Location		11/2			10d. Inside City Limits 1	
	MD 10e. Street and Nu 2900 Mer	mber	George's	Chev	verly	10f. Zip Code 20785			10g. Citizen of What Country?			
ed by Funeral	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces 1 Yes 2 I If Yes, Give Year or Dates.	?	S. 10	3. Was Decedent of I	an, Mexican, Puer		Jamaica 14. Race - American Indian, Black, White, etc. Specify: Black			
Completed	Elementary/Sec	onday (0-12)		5+)	(Giv life.	cedent's Usual Occu le kind of work done DO NOT use retired	during most of wo			Kind of Busines	s Industry	
To Be C	12 17. Father's Name Wycliffe	(First, Middle, Las	*		Lice	nsed Prac	18. Mother's Na	rse _{me (First, Middle,} n Harvey	, Maiden	ealthcai Gurname)	re	
	19a. Informant's N Courtney	Morgan				illing Address (Street			-			
	4 Donation	☐ Cremation 3 5 ☐ Other (Spe		e c	emetery, ci	position (Name of rematory or other pla Cemetery		Date 7 6/2011	l	ocation - City o	or Town, State Maryland	
	21. Signature of Fu	ineral Service Lice	ensee Hy Ryss		- 1	22. Name and Addre Gasch 's Fi		ome, P.A			timore Avenu Lle, MD 2078	
		in failure. List only (Final	mplications that cause one cause on each ling a. Due to (or as	ne. NY 57	nia	nter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Setween Onset and Death	
Examiner	Sequentially list or if any, leading to in Cause (Disease or that initiated event resulting in death)	nmediate nying linjury	b. Due to (or as									
edical			d								_	
Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 \$ 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of c	al death 3	Ectopic pregnan Other (specify)	су			23d. Date of o	delivery Day Year	
þ	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in the	e underlying cause g	iven in Part I.				to the cause of death? Probably 4 🏻 Unknow	
Completed								24a. Was auto perfo 1 □ Yes	psy ormed?	prior to death?	autopsy findings available o completion of cause of es 2 \square No	
Be	25. Was case referr examiner?	ed to medical	Hospital:			_ Ott	lace of Death (Che					
icate: To	27. Manner of Deat 1 X Natural 2 Accident		28a. Date of inj (Month, Da	ury	28b. Time injury	of 28c. Inju	4 ∐ Nursing F ry at	Home 5 Resi			ecify)	
l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of In	jury - At ho tc. (Specify,		street, factory, office		28f, Location (City or Tox			Rural Route Number,	
Medical	(Check 2 only one) 3	Medical Exa Certifying No	nysician: To the best ominer: On the basis of urse Practioner: To the	examination	and/or inv	estigation, in my opin e, death occurred at the	on, death occurred ne time, date and pla	at the time, date a	and place	e, and due to the	e cause(s) and manner stat	
		in	Bre	de			e number	3	29d. Da	ate signed (Mor		
			completed cause of 3001 Hosp				y, MD 2	0785				
te ar	31. Date filed (Mont			rar's Signat	wire			_				

DHMH 17 Rev 7/2009

Maintenance Supervisor

D.C. Public

18. Mother's Name (First, Middle, Maiden Surname)

Helen Johnson

Housing Authority

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ō items 23a Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Md.

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Allen E. Mackall

10th

College (1-4or 5+)

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be execu To the Funeral Director: completely filled in by the

Division of Vital Records, P.O. Box 68760

19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or I	Rural Route Number, City or Town, State	e, Zip Code)
Alberta Mackall/Wife	7222 Lorring Pl., Fore	estville, Maryland 2	20747
20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City	or Town, State
1		/07/11 Landover	Marvland
21. Signature of Funeral Service Licensee	22. Name and Address of Eacility Henry S. Washi	ington & Sons Co.,]	nc.
23a. Part 1. Enter the disease, or complications that caused	the death. Do not enter the mode of dving, such as cardi	iac or respiratory arrest,	Approximate
shock, or heart failure. List only one cause on each line Immediate Cause (Final	splastic Syndrome		Interval Between Onset and Death
resulting in death)	consequence of):		-
Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	consequence of):		
Cause (Disease or injury that initiated events			
	consequence of):		
d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 □ Unknown 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of Month	delivery Day Year
Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Diabetes Mellitus, Atria		1 Yes 2 No 3	Probably 4 🔀 Unknow
		24a. Was an 24b. Were	autopsy findings availab
		 autopsy prior performed? death 	to completion of cause of
25. Was case referred to medical examiner?		eath (Check only one)	
		Home 5 ☐ Residence 6 ☐ Other (S	pecify)
27. Manner of Death 1	y Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, street, factory, office (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the basis of and manner state	f my knowledge, death occurred at the time, date and pla examination and/or investigation, in my opinion, death occ ed.	Lee, and due to the cause(s) and manner curred at the time, date and place, and c	r as stated. due to the cause(s)
29b. Signature and title of certifier	29c. License number D65915	29d. Date signed (Mo	

DHMH 17 Rev 1/2001

State Registrar

1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chuanbo Zhang, M.D

31. Date filed (Month, Day, Year) MAY 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2011 BARBARA ANN NUNLEY 11:45AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY CECIL ELKTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days Hours 1 Day, , Year) 1944 NORTH_CAROLINA Director 220-54-7791 66 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f sl dical Examiner must be notified 1 ☐ Yes 2 No MARYLAND CECIL ELKTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 248 HOLLINGSWORTH MANOR 21921 UNITED STATES 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2XXNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: WHITE 3 - Widowed 4 - Divorced Specify: Completed er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 73 tof Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ CURRY RUSS MINIE BELLE ARMSTRONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MACK ARTHUR NUNLEY / SPOUSE 248 HOLLINGSWORTH MANOR, ELKTON, MARYLAND permit. Page 1 and 2:
Department of Health
Important; If item 27
any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETHEL CEMETERY MAY 4, 2011 Signature of Furn 22. Name and Address of Facility CROUCH FUNERAL HOME. P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Ph_{sician/} Onset and Death disease or condition resulting in death) Oello mycon Medical Due to (or as a consequence of) Examiner artice Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of that initiated events resulting in death) Last Physician/Medical COPD Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably 4 Duknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed Yes 2 after death.

Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 9 Other: 1 In atient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, mr car lan MD DO482 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 223

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MD

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

C HIH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5824 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 27 ay 2011 Year George Edward Nicholas 00:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea
March 21, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country 1 🖾 M 2 🗆 F Year) **Director** 228-56-8821 Yrs. 66 1945 Usual Residence of Decedent show at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sh notified a 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number r must be r ò 10f. Zip Code 10g. Citizen of What Country? with Funeral 10105 Leder Road 20902 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter the Medical Examiner 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 A No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance 12th Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. traumatic Margaret Nicholas unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Matthews - Sister 2002 Ridge Place SE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛂 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place)
Waryland
Veterans Cemetery May 5, 2011 4 Donation 5 Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Tension Pneumothorax Medical Due to (or as a consequence of) Examiner 10 years Asthma Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Yes 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Morbid Obesity Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown Polycythemia Vera 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy perform page 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🛂No မ funeral dir 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Afferd in by the furnishment Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760

altimore, Maryland 21215-0036

State Registrar

Francis Freisinger 1500 Forest Glen Road 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

reisinger

within 2

only one)

29b. Signature and title of certifier

ancis

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0070427

Silver Spring, Maryland

29d. Date signed (Month, Day, Year)

201

20910-1484

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** GERALD D. NELSON MAY 13 2011 5:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Chester River Manor Chestertown Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1₩ M 2□ F Director 009-52-6503 81 Dec 21 1929 New York Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo VT Bennington Bennington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lake Paran Rd. 05257 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled Mentally Handicapped 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Desmond Nelson, Sr. Alice Austen Acker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 permit. Pages 1 and 2 s
Department of Health al
Important: If item 27 is
any injury or other trau Alexandra Anthony 401 Second St. Crumpton, MD. 21628 20c. Location - City or Town, State (niece) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Kent Cremation Services 5/14/11 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 21. Signature of Funeral Ser 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY **Physician** CORONARY home disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Exami and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 X No 2 **Z**No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ν DHMH 17 Rev 1/2001

State Registrar Helen A. Noble, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

122 Speer Rd. Chestertown, MD. 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Day 2011 Month Physician/ 12 Lynne D. Norris 1:10 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day NOV • 20 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ^{Year)}19<u>48</u> 1 M 2 X F Days Hours Min Yrs. **Director** 217-46-1698 62 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits death with the Maryland the Medical Examiner must be notified at 1 Yes 2 No Baltimore White Hall MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21161 U.S.A. 2409 White Hall Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏞 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: "natural" 3 Widowed '4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Customer Service Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. မ Mary Doris Twilley Ellis Bedgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 White Hall Rd., White Hall, MD 21161 Pearce Norris/Husband Date 16, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Vernon UM Cemetery 4 ☐ Donation 5 ☐ Other (Specify) White Hall, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JJ Hartenstein Mortuary, PA 17349 N. Second St., New Freedom, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CENCE UDINCE WITA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signed page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 only one) 29b. Signatu 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

11-03243 Leroy Odom Phys Medical Ex

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

roy Odom		- For State	State o	f Maryland /	•	ment of ficate of		id Mental i		Reg. No.	2011	15827
Physicia	n/	Registrar 1. Decedent's Name	(First, Middle,Last)		-			<u>-</u>	Date of De Month	ath Dav	Year	3. Time of Death
edical Examir		Leroy 4a. Facility Name (if		treet and number)		Odom 4	o. City. Town. o	or Location of Dea	April 28,		unty of Death	12101115
		Laurel Regio		ara name er			Laurel			Prin	ce George	's
Funeral	- 1	5. Social Security Nu			(In yrs. last	birthday)	If Under 1 Ye		-		YYYY) 9. Birth Foreign	nplace (State or
Director	L	577–96–88		1 2 F	44	Yrs.	MOTHER	lys Hours IV	08-07	<u>-1966</u>	Was	Mington, DC
any	- 1-	Usual Residence of I 10a. State 1	Decedent 10b. County		IOc. City, To	wn or Locatio	on .				Т	10d. Inside City Limits
	٦	MD	Montgome	ry	G	aither	sburg					1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Num	nber				10f. Zip Code			10g. Citizen	of What Coun	try?
ith the 23a or notifie			eck Court	12. Was Decedent I		142 144	2088	lispanic Origin? (Specify Ves or I		J.S.A.	can Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	ner	11. Marital Status 1 Never Marrie	d 2 X Married	Armed Forces?	X No			an, Mexican, Pue		10-	White, etc.	Jan Haran, Siaon,
	J. F.	3 Widowed	4 Divorced	1 Yes 2 C Yes, Give Year or Dates:			Yes 2 X N					ACK
hours natur	Ped	15. Decedent's Edu Elementary/Secon	ucation (Specify only	highest grade comp				ation (Give kind of fe. DO NOT use r		1	of Business/Ir erline	ndustry
36 hin 72 e. than	Completed by Funeral	Elemental y/Secon	nuary (0-12)	2yrs.			Drive	er				corporated
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23s or 28s-f she ent, the Medical Examiner must be notified at once		17. Father's Name (F	First, Middle, Last)			3 1			me (First, Middle	, Maiden Sur	name) Odo	·m
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. a 27 is marked other than umatic event, the <u>Medica</u>	Be	Leroy 19a. Informant's Nar	me/Relationship (Tvr	e Print)	Hai	ghts	Address (Str	Patrice eet and Number o		umber. City o		
AD 2 2 shoul 27 is n	2	Tania Od				15 We	lbeck (ourt, G	aithersb	ourg, 1	Marylan	d 20886
re, N 1 and 1 Health Fitem	1	20a. Method of Disp	osition Cremation 3	Bamayal from Sta		ce of Disposi matory or oth	tion (Name of o	cemetery,	Date	20c. Loc	ation - City or	Town, State
Baltimore, MD 21215-0036 sermit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", nijury or other traumatic event, the Medical Examiner			Other Specify:		Han		emorial				_	Maryland
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 in injury or other traumat	1	ature of Fur	neral Service License			22. No	ame and Addre	ss of Facility Ro	onald Ta	ylor I	[I Fune lains.	eral Home Md. 20695
Physician	┪	23a, Part I. Enter the	e disease, or complic	alions that caused	he death. D	o not enter th	e mode of dyin	g, such as cardia	c or respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (F	y one cause on eacl Final disease a. N	fultiple Injuries								Death
}		or condition resultin	h	ue to (or as a conse	quence of):							
	ē	Sequentially list con if any, leading to im- cause. Enter Under	mediate D	ue to (or as a conse	quence of):							
	Examiner	(Disease or injury the	hat initiated C	ue to (or as a conse	quence of):		<u> </u>					
ecuted and transit			d									
60, ate be ex hysician e burial	Physician/Medical	UNPENDED		AMENDED				_		234 [ate of delivery	
6876 certificat nding phy	an/M	23b. Was decedent past 12 months	pregnant in the	23c. If yes, outcom			al death	B Ectopic pre	gnancy			Day Year
Box 6876 E death certificate the attending phy ed for use as the '	sici	1 Yes 2 N	_	4 Pregnant at 9 Unknown	time of	5 Oth	ner (Specify)			Į.		
O. B. at the de lby the lached f		Part ii. Other signif	ficant conditions		but not res	ulting in the u	nderlying caus	e given in Part I.			_	the cause of death?
F. P.O.	d by								- L			pably 4 Unknown
ords, w requir as been s	Completed									as an topsy rformed?		topsy findings available completion of cause of
Rec The la icate h:	E S								1 ✓ Ye	s 2 No	1 Y	es 2 No
Vital Records, hysician: The law require this certificate has been siderector, page 2 should be	Be	25. Was case referr examiner?	Ho	spital:	ot 2 🗸 E	R/Outpatient		Other Nu	eck only one) rsing Home 5	Residence	e 6 Other	r:
of Viting Physic After this	5	1 ✓ Yes 2 27. Manner of Death	2 No	28a. Date of Inju	ry 2	8b. Time of Ir		njury at Work?	28d. Descri	ne how injury		Allision
ion tendin eath. tor: A	atior	1 Natural 2 ✓ Accident	5 Pending Investigation	Apr 28, 2011	,	1105 hrs	1	Yes 2 No			or trailer co	
Division pital or Attendio ours after death. reral Director: A	Certification:	3 Suicide	6 Could not be determined	e 28e. Place of Inj	•		t, factory, offic	e building, etc.	or Towi	State)		ural Route Number, City ad, Laurel, MD
Lospita 1 hours 1 hours 1 hours		4 Homicide 29a. Certifier	Certifying Physicia	n: To the best of my			red at the time	date and place.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi	Medical	(Check only	Medical Examiner:	On the basis of exar and manner stated.	nination and	/or investigat	ion, in my opin	ion, death occurre	ed at the time, d	ate and place	, and due to th	ne cause(s)
E 3 E 8	Me	29b. Signature and	title of certifier					ense number				nth, Day, Year)
			Ante	1,200	4 ln ///	2-1		C.M.E.	-	April	29, 2011	
23		30. Name and addre	ess of person who co MD. Assista	ant Medical Exa	miner	900 W. Ba	altimore Str	eet, Baltimore	e, MD 21223			
		31. Date filed (Mont	th, Day,Year)	32. Registr	's Signature	Med.			· · · · · ·			-
Regis	ırar	MAYO	2011	as po	7							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No Pecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kichara APPT Physician 5:27 A M Dwight TIT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year July 22, 2 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 x M 2 □ F Hours Min. Mary Land 214-89-0185 Director 16 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD Director Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6624 Sanzo Rd., Apt. B 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: jo, 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) J Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Richard Pates, Jr. Mildred Dagcuta ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Mildred Pates - Mother 6624 Sanzo Rd., Apt. B, Baltimore, MD 21209 Health tem 27 i permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Saleii Bapt. Ch. Cenetery 4/11/2011 Spotsylvania County, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mullins & Thompson Funeral Service 21. Signature of Funeral Service License 1621 Jefferson Davis Hwy., Fredericksburg, VA 22401 MO1190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician persistent hyperkalemia Due to (or as a consequence of): disease or condition /Medical resulting in death) **Examiner** Due to (ur as a consequence of) Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner II or Attending Physician: The law requires that the death certificate be executed safter death.
Director: After this certificate has been signed by the attending physician and g physician and as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 1 Yes 2 No 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 🗙 No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury Accident 1 Tes 2 🗌 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital of 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the F 29c. License number 29b. Signature and title Res -000

Registrar
DHMH 17 Rev 1/2001

State

30. Name and

31. Date filed (Month, Day, Year)

back

600 North Wolfe St, Baltimore, MD, 21287

of person who completed cause of death (Item 23a) (Type, Print)

Wadia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30°, 20°1 April JOHN HERMAN PHILLIPS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartley Hall Nursing Home Pocomoke City Worcester 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 03/27/1913 213-05-7053 98 Director Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1926 Cedar Hall Road 21851 **USA** 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ John Burley Phillips Mary Z. Conaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Knight/ niece 409 Linden Ave., Apt. 309, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parksley Cemetery 5/3/2011 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Mu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and bunal-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ed by the a detached i P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, performed? Yes 2 No Division of Vital Hospital or Attending Physician: iours after death. Neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural Accident Suicide 5 Pending 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one)

20c. Location - City or Town, State Parksley, VA Holloway Funeral Home, P.A. Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5-2-201 2185

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

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Black White etc.

2:30P M

State Registrar

DN 5+1

29b. Signature ar

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31. Date filed (Month

Mar

30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

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32. Registrar's Signature

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month APRIL 2011 WARREN ALLEN RICE, SR. 09:35AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15 FRANCE LANE CECIL 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign HAVRING) DE GRACE MARY LAND 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Funeral 7. Age (In vrs. last birthdav 1 🗶 M 2 🗆 F Months Director 213-52-7127 64 FEB. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes XX No MARYLAND CECII 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 FRANCE LANE 21921 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LABORER MANUFACTURING should be filed with n and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ELSIE HICKMAN WALTER RICE ပ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY KILLEN / DAUGHTER 897EAST OLD PHILADELPHIA ROAD, ELKTON, MARYLAND 21921 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State GI fapita, (MANO) or other place)
MEMORIAL PARK Burial 2 Cremation 3 Remo MAY 6, 2011 ELKTON, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Neeplasm Physician disease or condition resulting in death) Mknach Medical Due to (or as consequence of): **Examiner** Sequentially flet es ditione, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed betached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been ral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🖳 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 🗌 Yes ည 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) in 24 hours after cocon. The Funeral Director: After this contacted filled in by the funeral di 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0023322 Jackelew S

Registrar DHMH 17 Rev 7/2009

State

126 A, E trief ST

Elsten MD 21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SACHDEV MN 126 A, E H

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 11,1971 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-19-5078 39 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State I and 2 should be filed within 72 hours after death with the Maryle Health and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 21740 U.S.A. 207 Summer Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 **X**√No Specify: 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceutical CO. Micro Biologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Saunders ဂ္ Sherlyn Melvina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Saunders Father 59 Saunders Drive, Falling Waters, W.Va. 25419 Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05-09-11 Manor Cemetery Tilghmanton, Maryland 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, Md. 21740 21. Signature of Funeral Service Licenses R. hoel Braa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal bleed **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** End-stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Be မ Certification:

The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, Division of Vital Records, P.O. ģ Director: After

filled in by the funeral director, page 2 should be detached

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Baltimore, Maryland 21215-0036

Health tem 27

Pages 1

hours after

To the Hospital o within 24 hours af To the Funeral Di Completely filled i

25. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigs			Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ome, farm, street, factory, of	fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
				, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)							

29c. License number

May; 2,2011 RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Bonerman

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signatu

31. Date filed (Month)



32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:25 AM Lois Bura11 Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fahrney-Keedy Home & Village Washington <u>Boonsboro</u> If Unde 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Min. Jan 6, Months Days Hours Director 90 577-26-1330 Maryland Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 Tes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 8507 Mapleville Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of tth and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irving Bura11 Edith Beachley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Gail M. Hill / daughter 5552 Clymer Road Quakertown, Pennsylvania item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05-05-2011 Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Signature of Fund 7606 Old National Pike Boonsboro, MD Enter the disease, or complication, or heart failure. List only one cal s that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans Exa that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending properties for use as IF FEMALE f yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death ned by the a P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 **¥** No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury work?
1 Yes 2 No Division Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year

Muhammad Waseem, MD 1126 Opal Court Hagerstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2011 Lee Staley, Jr. Joseph Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 7. Age (In vrs. last birthdav) Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🏻 M 2 🗆 F Months Sept. 13, 12941 Hours ^CMaryland 69 Director 213-40-4430 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 18616 Carolyn Street 21742 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? 1961 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 1965 3 Divorced Specify: Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Truck Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Lee Staley, Sr. Lolita Mae Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Staley-Wife 18616 Carolyn Street Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burjak injury or 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other Lawn Mem. Park May 6,2011 Hagerstown, Maryland OSBOTALATONEFATY Home, P.A. Conococheague St.Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hearl failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Phylician Bshol Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed' schemic 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical funeral director. Be 6. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 4 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of th 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Hatural 5 🗆 Pending Accident M 2 No Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F Agertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, 162588 a upro *1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDITH MEAOUR, TD IIII6 Hedical Campus Rood. Hayershown no 21740 MBAOUA, TLD JUDITH

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{pay} 201 Year Month 10:30A M Betty Mae Spence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** CountryPA Months Hours 1 □ M 2 ⋤ F November 24, 1926 Director 159-20-6425 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he professione. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD St. Mary's Mechanics ville 10e. Street and Number 10g. Citizen of What Country? Funeral 37481 Harrow Hills Court 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Food Service Vending Machine Servicer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sherdian Uncapher Blanch V. Buttermore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Barkley/Daughter 8460 Ice Crystal Dr. Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Maryland National 1 XBurial 2 Cremation 3 Removal from State 5/5/2011 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 20646 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Unidenying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abdominal hernia, Bowel doskuction 1 Yes 2 No 3 Probably 4 Unknown Amal Aballaton, Elevate 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Demonhia performed 2 🗌 No Yes 2 XNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 😾 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending neral Director: A Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier MD 29c. License number INTERNIST D263173 05/02/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahit Siddiqui, M.D. 24035 Three Notch Rd. Hollywood, MD 20636

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

11-03393 Charles Southcomb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Southco		S 1- For State Registrar	tate of Maryla		artment of rtificate of		nd Menta	al Hygie		. No. 20	What is	835
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)	IGI	Charles G. S 4a. Facility Name (if not instituti			41	. City, Town, o	or Location of		ay 5, 201	4c. County of	0911 hrs	•
_		10002 Coastal Hwy	Unit 409			Ocean City	y			Worceste	r	
Funeral Director		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da		T		` 1	Birthplace (State of Foreign	or
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2 7	eted	Elementary/Secondary (0-12)			during mos	t of working life	e. DO NOT u	se retired)	lone	ob. Kind of Busi	ness/industry	
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Baltimo permit. Page Department o Important: injury or ott	ł	4 Denation 5 Other S 21. Signature of Fungral Service	pecify: Licensee	C	edar Hi		m •	5/10/	/2011	Balti: Funera	more, MD	
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Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 CertifyIng PI (Check only 1 Medical Exa	nysician: To the best of miner; On the basis of	of my knowledg	ge, death occurre	at the time, d	ate and place	e, and due to	the cause(s	and manner as	s stated.	
To th withi To th	ᇟᆫ	29b. Signature and title of certifie	and manner sta	ted.		29c. Licens		rred at the ti			(Month, Day, Year)	
	-	1111	6		nn	O.C.				May 6, 2011	, Day, 16ai)	
941	-	30. Name and address of person		of death (Item								
DN		Russell Alexander MD				Baltimore	Street, Ba	altimore,	MD 2122	3		
Sta Registr		31. Date filed (Month, Day, Year)	1 2011 /2	strar's Signatu	A has	N.						

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2011 /Medical 4a. Facility Name (In not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Washington, D.C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 9, 1942 578-56-5786 68 Auq. Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be netited at 10b. County Directo 1 ☐ Yes 2 X No Sussex Millville DE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19970 USA 36 Dover St. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice Griffin Mary B. McLaughlin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Maurice B. Griffin / Brother Pomfret. 8715 Patricia Ct., MD 20675 injury or other Baltimore, if item 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Pages 1 permit. Page:
Department c
important: if
any injury or
once. 1 ☐ Burial 2 ☐ Cremation 5/2/2011 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Dagth Immediate Cause (Final **Physician** NO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-trans and Due to (or as a consequence of) Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. detached 1 Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 1NC ospital or Attending Physician: hours after death. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, 27. Manner of Death 28h Time of 28d. Describe how injury occurred Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

J-(a (f) 74 km y 1 19, Year) 32. Registrar's Sig

fistrar's Signature B. Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> April 5:08 Physician/ Irving Swartz 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Regency Park Assisted Living Gambrills If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral June 2, 1926 1 X M 2 □ Months Davs Hours Min. New York 088-20-6905 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Crofton MD Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a the Medical Examiner must b Funeral USA 1506 Rochester Ct. 21114 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Truckina Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked Becky Mufson Louis Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD Wyatt G. Cook / step-son 1506 Rochester Ct., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State □XBurial 2 □ Cremation 3 ☒ Removal from State Department o Important: If any injury or ō Beth David Cemetery 4/29/2011 Elmont, NY 4 Donation 5 Other (Specify) 21. Signature / Funer / Solvice Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between ns and Death Immediate Cause (Final Physician/ mentra disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to inmediate cause. Enter Underlying Cause (Disease or iinjury Director as a nunsecuring off Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autonsv death? perform 2 110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Praction only one) 29b. Signature and title 29d. Date signed (Month.

State Registrar 31. Date filed (Month

15,00

Md, 210

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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		Funeral	Г	5. Social Security N			Age (In yrs. I	ast birthday)	If Under	r 1 Year Days	If Under 24 H		Birth Dev Year)		place (State or Fo	oreign
		Director		578-60-3 Usual Residence of	f Decedent	7 2 11 2 2						03701	/194	6	Wash	D.C.	
		laryland 3a-f shc iffied at	ector	Md.	10b. County Montgo	omerv		y, Town or Lo .lver S		7					1	0d. Inside City L	
		th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Nur						Code 2090)6	-	10g. (Citizen of W	/hat Cour		
5	36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at , the Medical Examiner	þ	11. Marital Status 1 Ϫ Never Man	ried 2 🗆 Marri	12. Was Deced	es? 2 QNo	'	f Yes, spe	dent of His	spanic Origin?	Specify Yes or No erto Rican, etc.)	D-	14. Race	- Americ	an Indian,	
7	2-00	hours:	Completed	3 Widowed	15. Decedent	Year or Date	es	16a. Deced	lent's Usu	al Occupa		n skin a	16b.	Kind of Bu		erican dustry	
8	2121	ed within 72 Hygiene. other than '		Elementary/Sec		1 College (1-4	or 5+)	life. D	unse.	e retired)	uning most of w	orking	Me	ental	ly C	hallenge	ed
Stanta	Maryland 21215-0036	e filed ntal Hy ed oth event	To Be	17. Father's Name ((First, Middle, La lie Stra	-					18. Mother's N Queen I	ame (First, Middl)unlap	e, Maide	n Surname))		
a		2 sho Ith an 27 is 1 trau		19a. Informant's Na Geneviev		p (Type, Print) news/Aunt		19b. Mailir 4800	eg Address	Street a	nd Number or I	Rural Route Numl	ber, City o 7 , Wa	or Town, St shing	ton,	D.C.2001	19
×	Baltimore,	Page 1 nent of ant: If it ary or o			•	3 ☐ Removal from Specify)	tate	Place of Dispo cemetery, cren Linco	natory or o	ther place	e) 05	12 / 02/ 11	1	Location - entwo	-	wn, State aryland	
Siana	Balt	permit. Departr Imports any inju		21. Signature of Fu	ineral Service Lid	censee 5	nall	- 22 4	hen 925 I	d Addres Burro	ร ฟิสิริกir bughs Av	ngton & : re.,N.E.	Sons ,Was	Co., hingt	Inc. on,D	.C.20019)
C,				23a. Part 1. Enter t shock, or hea Immediate Cause	art failure. List or	complications that canly one cause on each	used the deat	h. Do n o t ente	er the mod	le of dying	g, such as cardi	ac or respiratory	arrest,			Approximate Interval Betwee Onset and Deat	en th
3	Q	Physician/ Medical Examiner		disease or condition resulting in death)	on	a. Due to (or	r as a consequ	ueno of):	tu.	10	istre	S 24	~ C	COME		Twee	
3			iner	Sequentially list con if any, leading to in cause. Enter Unde	imediate 1	b. Due to b	as a consequ	-	ck	-			_		-	Twee	K
M	0	e be executed ysician and e burial-transit	ical Examiner	Cause (Disease or that initiated event resulting in death)	linjury ts	c. Due to (or	r as a consequ	uence of):	~	O _I	dan	Carl	W			2 wel	LKS
ations	. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ↓ 9 ☐ Unknown	months?		rth 2 Teta ant at time of c	aldeath 3 🗆	Ectopic Other (s _f		у			23d. Date Mor	e of delive	ery Day Year	
	ls, P.O	uires that t n signed b ld be deta	ed by P	Part II. Other signif	ficant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying	cause give	en in Part I.			. 1		e cause of death	
	Division of Vital Records,	he law requite has been age 2 shou	Completed by	Aver	nia				·			24a. Wa aut per 1 □ Yes	opsy formed?	p d	rior to co eath?	osy findings avail mpletion of cause	
	ital	sician: T certifica rector, p	Be	25. Was case referred examiner?	red to medical	Hospital:				LOtho	ace of Death (C/	neck only one)		104			
	n of V	ding Phys h. After this funeral di	cate: To	27. Manner of Deat	h 5 Pending	28a. Date of (Month)		ER/Outpatier 28b. Time of injury		8c. Injury work?	4 ∐ Nursing at	Home 5 Res)	
	ivisio	I or Atten after dea' Director: d in by the	Certificate:	3 Suicide 4 Homicide	Investiga 6	ot be 28e. Place o	f Injury - At ho , etc. <i>(Specify</i>	ome, farm, stre			103 2 110	28f. Location City or To			r or Rural	Route Number,	
		e Hospital or 124 hours afte e Funeral Dir leted filled in	Medical ((Check 2	Medical Ex	Physician: To the bestaminer: On the basis Nurse Practioner: To	of examination	n and/or invest	igation, in	my opinio	n, death occurre	d at the time, date	and place	ce, and due	to the car	use(s) and manner	r stated.
		To the within 2 To the comple	2	29b. Signature and	-	K.	A	P		. License)		ate signed			
(1)	2	,		30. Name and addr	ess of person w	ho completed cause	of death (Item		1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	- _ ()	1 2	, , (,		WII	
4		Sta	te	31. Date filed (Mont	Ment 3 2011	32. Reg	jistar's Signat	ture	<u>o.</u>	MA	2001	617	214	ma	a		
		Registra	ar	UIAM	3 2011	(Maria)	M. 17	_									

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 24 Pay 2011 Pearl A. Scott 12:42p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Fort Washington Hospital Fort Washington Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Min 10-9-1908 Months Hours 207-20-2080 Virginia 102 **Director** Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No MD Fort Washington Prince Georges 10e Street and Number ъ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 1702 Tioga Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black "natural", Completed 3 Midowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Nurse Private Care Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Taylor Martha Evans permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Pruden/Daughter 1702 Tioga Rd. Fort Washington MD 20744 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State White Chapel Memorial 5-2-2011 Seasterville, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home LLC any inj once. Funeral Service License 3005 12th Street NE Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Sersis) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a conse uence of: -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed 2 þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛛 Natural 5 Pending iniury work s after death.

I Director: Aff 1 Yes 2 No Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 5 a 2011

State Registrar D46741

11711 Livingston Rd. Fort Washington MD 20744

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Sachdeva,

Deepak

MAY 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc ago 55-26-11 yt Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Martha Williams Shaw **Physician** <u>1625</u> 05 2011 Margaret Williams 10 Shaw /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Frostburg Village Nursing Home
Social Security Number 6. Sex 7. Age (In yrs. Allegany Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Min 215-26-7189 82 Director 1928 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It w Mudical Exertines must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Allegany Mt. Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Columbia Ave. 21545 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Mary McKenzie Blank Carl J. Blank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 714 Nemacolin Rd. LaVale, MD 21502 MArsha Steiner daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Patrick's Cemetery 5-13-2011 Mt. Savage, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sowers Funeral Home, P.A. 60 W. Main Street Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 month **Physician** Demontia advunced /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy r this certificate haral director, page 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To s after death.

I Director: After this of in by the funeral d 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) --State Registrar

Bishop Walsh Rd Camberland Mp 21502 WORKOCK SHIN MD 925

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0055325 Mary 11,201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marjorie Dean Woodruff Month Medical pRI 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F 96 505-16-1792 Day, Year) 1914 Fairbury, Nebraska Director November Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7308 Lois Lane 20706 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", Completed Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 72 hotal Hygiene. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If item 27 is reary injury or other. and Mental is marked ပ Charles E. Churchill Donnie B. Bulson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet R. Woodruff / Daughter 7308 Lois Lane, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/4/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 own 23a. Part 1. Enter the disease, or combilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only or cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 🔀 No 1 ☐ Yes ∠ ≝ 9 ☐ Unknown the 9 Unknown n signed by th. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No After this certification of the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 X No 1 Yes Other: 잍 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation Director: / 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of MDD 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George 7500 HANOVER Parkway Suite 101A Greenbelt MO 20170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

MAY 0 3 2011

, mark loper

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Please Type or Print in Black Indelige Ink Inspire All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Voar Physician/ 10:10 A M Mary Ann Weaver 2011 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year,
Dec. 18, 1 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday Funeral 1 🗆 M 2 🔀 F Months 219-20-4749 82 Director 1928 Maruland Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland ŧ Director r 28a-f sl notified 1 XYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral with 1 453 Clarendon Ave. 21740 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DC NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Grocery 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked or other traumatic ev 2 Max Bowman Frances E. Waters 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Weaver 10800 Anderson Dr. Williamsport, Maryland 21795 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott May 13 2011 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onsat and Death Immediate Cause (Final Physician disease or condition) Medical resulting in death) et (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 🔀 No jo Month Year Day Other (specify) Pregnant at time of death signed by the a 9 | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed Ves 2 14 No has death? 1 Yes 2 1 Yes 2 No this certificate 25. Was case referred to medica examiner? Division of Vital 26. Place of Death (Check only one) director Be 2 XNo 1 Tes 잍 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Iniury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 \(\text{Yes} death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

1126 Opal Court, Hagerstown MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr Muhammad Waseem,

			For State	State of	Marylan	•	artment of H		and M	ental Hyg	iene	1 1 1	15010
			Registrar 1. Decedent's Name (First, Middle, La.	st)		Cer	tificate of L	Jeath		2. Date of Deat	eg. No	1 1	13843
	Physicia		Yang	Yav						May		2011	3. Time of Death 0/48 M
	Medic Examin		4a. Facility Name (if not institution, give		er)		4b. City, Town, o	r Location o	of Death	ricy	1	ty of Death	07 10
			Meritus Medical C	enter			Hagers	town			Was	hingt	on
	Funeral		Social Security Number 6. S 1	ex 7. □ M 2 X] F	. Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Count	lace (State or Foreign
-	Director		213-51-6243 Usual Residence of Decedent		84	Yrs.				(Month, Day, 7/7/19	26	Camb	odia
	and show	or	10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10	0d. Inside City Limits
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	filed within 72 hours after death with the Maryland tral Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	io Je	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Coun	try?
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	r deal		11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decede Armed Force	es?	S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Spec , Puerto P	rify Yes or No- lican, etc.)		ace - America ack, White, e	
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Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Liven	9	1 2111	22	. Name and Addre	ss of Facility	Rest	Haven	Funera	1 Char	nel
n	e a L C	Ġ	12 T. 13	un									land 21742
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that cau	used the deatl	h. Do not ente	r the mode of dyin	ig, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	-1	- 1					
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9/9	ificate ng phy as the	Med	IF FEMALE:										
X 68	h cert tendir r use	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna		Ectopic pregnanc	CV				ate of delive	ery
X Q Q	death the atte	/sici	1 Yes 2 No	4 ☐ Pregna 9 ☐ Unknov	nt at time of c	death 5	Other (specify)				M	1onth	Day Year
j.	that the ned by the detach	Phy	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e Did toh	acco lise con	atribute to th	e cause of death?
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DIVISION	or At after of Direct in by	Certificate:	4 Homicide determined	28e. Place of	Injury - At ho , etc. <i>(Specify</i>	me, farm, stre	et, factory, office		2	8f. Location (Str City or Town		ber or Rural i	Route Number,
5	pital ours a eral [29a. Certifier 1 Certifying Phy	cicion. To the bee	t of my lenous	ladaa daath a	accurad at the time	data and s	dana and	-l	(-)1		1
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	(Check 2 Medical Exam	iner: On the basis	of examination	n and/or invest	igation, in my opinio	on, death oc	curred at t	he time, date an	d place, and d	lue to the cau	se(s) and manner stated.
	To th Withir To th Comp	2	29b. Signature and title of certifier	/ 2		() = 1	29c. License		and place		9d. Date sign		
			> Vu pri	MOST	2 ta	KI ST	Do	059	416	4	5/	11/20	511
			30. Name and address of person who			23a) (Type, P	D o rint) 6 Medi					-/-	
			Vladimirica	Khman)	6 Medi	cal (arry	aus Rd	. Huge	Stown	MO21742
	Stat Registra		31. Date filed (Month, Day, Year) MAY 1 7 9	32. Peg	istrar's Signat	A L	ukal				5		
	J		PIRTILL			NOT 1 AST N							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day 2011 Year May Physician/ 11:58 PM Ruth Brechbill Zercher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 13508 Marsh Pike Hagerstown 8. Date of Birth Jungth, 20, Year 1919 9. Birthplace (State or Foreign . Social Security Number 161-32-5642 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Kansas 1 □ M 2 🛣 F 91 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director Maryland Washington County Hagerstown 1 ☐ Yes 2 🕅 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be Funeral 21742 U.S.A. 13508 Marsh Pike Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Yes 2 No δ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other thal any injury or other traumatic event, the N Nursing Home Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abigail Climenhaga Brechbill Jesse Engle Brechbill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13508 Marsh Pike Hagerstown, MD 21742 Jane Z Stauffer-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grantham Mem. Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State 5-7-2011 Grantham, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or exterior or cardiac or respiratory arrest, shock or the cause of th Approximate Interval Between Onset and Death Physician/ months erebrovascu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has ral director, page 2 performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation gompleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifier

the Kuther-Sando, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Underlined the cause(s) and manner as stated.

Underlined the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hospice of Washington County

D47451

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-2011 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner You hATTAN BEACH RD. PASADENA ear If Under 24 Hrs. avs Hours Min. If Un 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Country) Director r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 You 10g. Citizen of What Country? Funeral U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. 41 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me filed within Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evenes. ပ ANTON ZORNAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PASADENHALD . Z1122 STEVEN ZORNAK, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 5-17-2011 BROOKLYN PARK, MD. 4 Donation 5 Other (Specify) 21. Signat 22. Name and Ad ress of Facility DAUGHERTY FUNERAL HOME PASADENA, MD. Z1122 Part 1. Enter the disease, or c tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate bauce. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Medical Examiner: On the basis of examination and of infectional place, and due to the cause(s) and manner as stated
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 05, 11, 2011 りりろうひ WB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wareto 0091

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of		partment of Health and ertificate of Death		ene 2011	15846
3	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
94.	Medi Examir	cal	Lena M. Allen 4a. Facility Name (if not institution, give street and num	nber)	4b. City, Town, or Location of De	9	26	111954 м
	, Examin		Union Memorial Hospita	,	Baltimore	atti	4c. County of Deat	n
	Funeral Director		5. Social Security Number 238-72-3039 6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. Biri 944	thplace (State or Foreign untry) unk
	show dat	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Maryla 28a-f otified	irect	MD	Bal	timore			1 √Yes 2 □ No
	ith the 23a or st be n	Funeral Director	10e. Street and Number 8555 E. 30th Street		10f. Zip Code 21218	10	g. Citizen of What Co USA	untry?
	death v items		11. Marital Status 12. Was Dece Armed Fo	edent Ever in U.S. 13.	. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ame	
9036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 X Widowed 4 ☐ Divorced Year or Da	2 X No	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 🌠 No Specify:	erto Ricari, etc.)	Specify: b1	,
15-0	72 hou n "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of w	unk 1	6b. Kind of Business	Industry unk
212	within giene. er tha		Elementary/Seconday (0-12) College (1 unk	-4 or 5+) life. I	DO NOT use retired)			
Maryland 21215-0036	d be filed Aental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last)		unk 18. Mother's N	lame (First, Middle, Ma	uiden Surname)	unk
	permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship (Type, Print) Union Memorial Hospital	19b. Mail L 201	ing Address (Street and Number or I E. University P	Rural Route Number, C kwy Baltim	ity or Town, State, Zip	20 Code)
Baltimore,	Page 1 ar ment of He tant: If iter iury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☑ Other (Specify) in st	ate	osition (Name of matory or other place)	Date 20	0c. Location - City or	Town, State
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licentee D		2. Name and Address of Facility State Anatomy Boa Baltimore, MD 21		Baltimore	Street
			23a. Part 1 Enter the disease, or complications that c shock, or heart failure. List only one cause on ea	aused the death. Do not en	ter the mode of dying, such as cardi	ac or respiratory arrest	,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	or as a consequence of):	serebellar s	troke		Onset and Death
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	icate be executed physician and sthe burial-transit	<u> </u>	that initiated events c.	or as a consequence of):				
200	physici the bu	edical	d					
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ls, P.O.	uires that in signed uld be del	Completed by F	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?
Records,	faw require has been s e 2 should	nplet				24a. Was an autopsy		opsy findings available ompletion of cause of
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n of	ding Phy th. After thi funeral		27. Manner of Death 28a. Date of 1 ☑ Natural 5 ☐ Pending (Month		f 28c. Injury at work?	28d. Describe how		<i>y</i> /
Division of Vital	Attender deat ector:	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place	of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No eet, factory, office		et and Number or Rura	al Route Number,
Ο̈́	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the			g, etc. (Specify)	occured at the time, date and place,	City or Town, S	,	
	the Hos hin 24 h the Fur npleted	Med	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: T	s of examination and/or inves	tigation, in my opinion, death occurred death occurred at the time, date and p	t at the time date and r	slace, and due to the or	nuco(c) and manner stated
	Note that	1	29b. Signature and title of certifier	17	29c. License number	29d	Date signed (Month,	Day, Year)
		-	30. Name and address of person who completed cause	of death (Item 23a) (Type, I	Print) 24380	176-176	116712	
			RYANE A EDMONDS Z	01 East U	Nivelity Park	way Ba	HIMORE ,	AISIR QIN
	State Registra		MAY 1 8 2011	gistrar's Signature	41	•		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 15847 State of Maryland / Department of Health and Mental Hygiene ZUII Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICHARD C. ANDERSON 11:40A M MAY 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 21236 County Baltimore 4525 Ridge Rd. 8. Date of Birth (Month, Day, Ye 1ay 26 1950 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **X**X M 2 □ F Months 60 216 50 3403 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore County 1 Yes 2XX No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 4525 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married XX Yes 2 No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 1968-1970 Specify: White 3 Widowed XX Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Body & Fender Technician Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anita Mae Grammer Charles Edward Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21236 4525 Ridge Road Leslie F. Taylor (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery May 17, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility

Priysiciani Medical Examiner

permit. Page 1
Department of I
Important: If it
any injury or or

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

Director

Funeral

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Completed

Be

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant. If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

the burial-tran for use as

the attending physician signed by completed filled i by the funeral director, page 2 should be this

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending within 24 hours are death.

To the Funeral Director: After of person who completed cause of death (Item 23a) (Type, Print) Yousuf 31. Date filed (Month, Day, Year) NAY 18 2011 State Registrar

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lical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If so yield on moderate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	a. Due to (r as a sequence) Due to (or as a consequence) Due to (or as a consequence)	To not enter the mode of the state of the st		or respiratory arrest,		Approximate Interval Between Onset and Death 3000 S
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown portributing to death but not resulting	eath 3 Ectopic th 5 Other (s	specify)	1 ☐ Yes 24a. Was an autopsy	No 3 F	Day Year Day Year The cause of death? Probably 4 Unknown Untopsy findings available completion of cause of
Cou					performed?		s 2 No
o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	/O	26. Place of Death (Che		• -	
icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	b. Time of injury	28c. Injury at work? 1 Yes 2 No	Residence 28d. Describe how inju		olfy)
I Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (Street a City or Town, Stat		ıral Route Number,
Medical Certificate:	(Check 2 Medical Examir	ician: To the best of my knowledg ner: On the basis of examination and Practioner: To the best of my knowledge.	d/or investigation, in	n my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier		29	Oc. License number		ate signed (Mont	h, Day, Year)

TOWSON MD 21204

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ Jean Allison 50A 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A Joseph Ritchey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 8. Date of Birth Social Security Number **Funeral** 1 🗆 M 2 💢 F Days Hours Country) 59 212-60-2714 Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10c. City, Town or Location Director 1X Yes 2 No N/ABaltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21221 951 Punjab Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Homemaker 12th N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Minnie Hardy Anderson Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6306 Everall Ave. Baltimore, MD 21206 19a. Informant's Name/Relationship (Type, Print) Damon Allison- Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 5/19/2011 Arbutus, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North 21. Signature of Funeral Service Licensee Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) metastalis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Hyperension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No M Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 13,2011 HOO 62554 SHEN, DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOR MD CynThia HOSP. GE Shen Joseph 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Keith Robert Anderson MO 5/09/2011 Year 11:04am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Med Cent. Anne Arundel Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Sex 1 XM 2 D F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 216-80-5091 Days Hours Country) CA MOT 227 1958 52 Director Usual Residence of Decedent 28a-f shov 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD Anne Arundel Severn 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? must be n Funeral 1627 Shannon O Circle 21144 USA Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Completed Specify 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2yrs Elementary/Seconday (0-12) Tech Tec Information Cable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Betty Edmonds John Anderson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 527 Shannon O Circle Severn MD 21144 Department of Health ar Important: If item 27 Is any injury or other trau Eric C. Anderson Brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atcarately transfor Crether place) 05/11/2011 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD 21. Signature, of Funeral Service Light Fun Serv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 \square Yes 2 B.M 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury death. 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖵 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier peted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DCC05829 30. Name and address of person who completed cause of death (Item 2 M anny 32. Registrar's S State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MA Physician/ EONARD ADLER 10:25 PM 1 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD GENERAL HOSAITH HOWARD COUNTY COLUMBIA 6. Sex 1 X M 2 \square Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Hours 01/27/1926 Months NY Director 063-20-3796 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No ELLICOTT CITY MD HOWARD 10e. Street and Number 10g. Citizen of What Country? Funeral USA 3010 N. RIDGE ROAD, #509 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ Black, White, etc þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) ELEMENTARY EDUCATION 5+ TEACHER AND PRINCIPAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ADLER **THERESA** ETS NAIMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10762 JUDY LANE, COLUMBIA, MD JENNY LEOPOLD/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 05/16/2011 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee May 10 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final BLEED (HEMORPHAGE ULCER Physician/ DUODENAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 6876Ó IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 4 ☐ Pregname 9 ☐ Unknown ☐ Yes ∠ ∟ ☐ Unknown this certificate has been signed by the raid irrector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: ျ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After Natural Accider 5 Pending 2 🗌 No Accident Investigation after death Director: A 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY D50404 13 2011 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24044 #111 PATHLENT PKWY 10632 COLUMBIA, MD ALKESH PATEL LUTTLE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. amend item 8, per fh, g915 5-18-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Month ZO \ Physician/ 2 Day 6:15 PM larion DUSCO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Home Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 119-18-2087 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 X 84 NY Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 9 Braided Whip Court 10f. Zip Code 10g. Citizen of What Country? 21244 Funeral USA Hygiene. other than "natural", or items: 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Black Completed by 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examii Never Married 2 Married 1 ☐ Yes 2 🗷 🗙 o If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Nurses Aid Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Samuel Brisco Palmer Sara permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Sabrina N'diaye 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)
er 9 Braided Whip Ct. Baltimore MD 21244 /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Maple Grove Cem. 1 Burial 2 Cremation 3 CRemoval from State 5/3/11 Kew Gardens, NY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor Doda²² Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore M Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Disease disease or condition resulting in death) oronary Medical Due to (or as a consequence of): Examiner Atrial 8pul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) as been signed by the attending physician and 2 should be detached for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Disease monan Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) ☑ Natural 5 Pending injury Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signa License number D0053337 28 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Are 2835 te 203 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2011 Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month James S. Bogoslowski 14 9:20P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson <u>Stella M</u>aris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7, Age (In vrs. last birthday, 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months Hours Min Days Maryland Director 218-28-7468 Usual Residence of Decede 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 4420 Eldone Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify. Completed 3 X Widowed 4 □ Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) Mfq. 12 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, d 2 should be filed alth and Mental H 27 is marked of ၉ James S. Bogoslowski Vincentina Boguslawski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 4420 Eldone Road, Baltimore, Maryland 21229 Robert Bogoslowski / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Page 1 5/19/2011 Glen Burnie, Maryland Glen Haven Mem. Pk. Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. native of Funeral Service Ligensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to for as a consequence of, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death 2 🗌 No the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed iis certificate has been si director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Director: After this certificate I 1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar DHMH 17 Rev 7/2009

2

14, 2011

JAMES BOGOSLOWSKI

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

JONES

18 2011

29d. Date signed (Month, Day, Year)

MD 21093

TIMONIUM.

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend \$3. per M DG915 5/18/11 TT
State of Maryland 7 Department of Health and Mental Hygien [] | | 15853 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.3 10 Death Physician/ Month 05 2011 Year 4:40 AMM <u>Paul Rene Bondoc</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale 4 Camrose Court Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Hours 02/26/1969 **Director** <u> 222–60–7783</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Rosedale 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 4 Camrose Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Shourd be man and Mental Hygiene.

7 is marked other than "natural avent, the Medical E. Filipino 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) aryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Senior Network Administrator Carroll Fuels & Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn Teresita Duterte traumatic Rene Luis Torres Bondoc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 4 Camrose Court - Rosedale, Maryland Lisa Bondoc 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/19/2011 Baltimore, Maryland 21, Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical r as a onsequence of): **Examiner** Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has yes 2 X 2XNo 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how 5 Pending 1 Natural work? 1 ☐ Yes 2 🕱 No Hanging ror Rural Ro e Number my oge C May 15 201 (340 A M 1 L 28e. Place of Injury - At home, farm, street, factory, office .Accident Investigation 24 hours after death Funeral Director; 3 Suicide 4 Homicide 6 Could not be Place of Injury - Action building, etc. (Specify) 28f. Location (Street and Number or Ru. City or Town, State) Licams completed filled in by determined oal Mary and 212.37 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Priystician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title son who completed cause of death (Item 23a) (Type, Print 30. Name and address of pe State

Registrar

3400

O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carolyn W. Bolster 145M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 S Months Days Hours April Day Year Maryland 579-12-9740 90 192**1** Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Examiner must be Funeral 3474 Gleneagles Drive 23a 20906 United States items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes PNo Specify. Specify: White If Yes, Give 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ August Denhardt Werner Bessie Fahey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Bolster / Daughter P.O. Box 153 New Oxford, Pennsylvania 17350 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/18/2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of uneral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Custo for as a prasequence cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. I signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, in ection Tract icate has been sig page 2 should b Completed Vrinary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? Thrombosis 24a. Was an vinous autopsy performed?
1 Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | | 3 | | only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M Pinh Bichhun 54996 10 2011 May 30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)

Bichhuong M. Dinh 18101 Prince Drive , Olney Philip 31. Date filed (MoNo, Day, Year) 82. Registrar's Signature State MAY 18 2011 Registrar

M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea Physician/ Baldwin Sr. Foster Darnell 05 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2500 West Belvedere Ave Apt1012 Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 08 18 1 🕅 M 2 🗆 F Days Hours Months Min. Year) 212-42-7010 **Director** NC Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d Inside City Limits Examiner must be notified at Director Baltimore 1 X Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21215 U.S.A. 2500 West Belvedere Ave Apt1012 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Boiler Plant Operator Childrens Center 8th grade na Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ၉ Margaret Etta Holland and 2 should be Lewis Henry Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3011 Milford Ave, Baltimore, Md 21207 <u> Michelle Baldwin-Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 (cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 (Control Other (Specify) King Memorial Park 5/20/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Sign Funeral Service Licensees 4300 Wabash Ave, Baltimore, Md Part . Enter the di show, or heart fai se, or complications that caused List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine DEPENDENT burial-transit and resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hasl autopsy performed After this certificate 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.

I Director: After this certificat Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral in the fune 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DR. S 501 21204 **FACE** TOWSON, MD. CEBALLOS, M.D

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (*Month, Day, Year*) **MAY 1 8 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5:45p 10/2011 15° 10/20° 11 Physician/ Virginia W. Bates Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Parkville 2508 Parktrail Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month Month, Day, Year) 6/8/1919 1 □ M 2 🛣 F 91 MD 213-28-2736 Director Usual Residence of Decedent 10d. Inside City Limits show or 28a-f shov notified at 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 No Parkville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or ner must be n ō Funeral USA 21234 2508 Parktrail Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status "natural", or iter edical Examiner Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 ₩ Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Domestic and Mental Hygiene. Various Jobs N/A 6th Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Edith E. Nickens 2 Thomas I. Dennis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) l and 2 should b f Health and Me 19a. Informant's Name/Relationship (Type, Print) 2508 Parktrail Rd. Baltimore, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Stevie B. Bates Sr.-Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a, Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Mem. Park 5/18/2011 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North 21. Signature of Funeral Service Licensee Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final inentl Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of) cause. Enter Underlying Exami Cause (Disease or iinjury tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred

P.O. Box 68760 Division of Vital Records,

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and funeral director, completed filled in by the To the Pwithin 2

27. Manner of Death

1 Natural

Accident
Suicide

3 ∐ Suicide 4 ☐ Homicid		28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office		(Street and Number or Rural Route Number, wn, State)
29a. Certifier (Check only one)	2 Medical Evamine	ian: To the best of my knowledge, death occurer: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s) and manner stated
only only					and Division Little Constitution

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

5 Pending

Investigation

6 Could not be

29c. License number 1320396

28f. Location (Street and Number or Rural Route Number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raven 54.103 och

State Registrar

Certificate:

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>11</u> April Physician/ 17 3:30 AMM Alice L. Basile Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Emeritus Assisted Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 6. Sex . Age (In vrs. last birthday) 8. Date of Birth Days 1 🗆 M 2 💢 F Months Hours July 17, Pay Year 1924 Maryland Director Yrs 86 216-16-9114 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2X No Bel Air MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 294 D Canterbury Road items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian , or Black, White, etc. 1 Never Married 2 Married þ 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify. white "natural". Completed 3 x Widowed 4 □ Divorced 1945 Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. photography self employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mabel Richardson f Health and Ments item 27 is marked other traumatic e Thomas Sudler Andre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria LoBianco/daughter 8417 Kellogg Court Lutherville, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Qther (Specify) Funeral Service Licenses Director State and the Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ mentic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or i that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No signed by the atte d be detached for Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 🗌 No 1 Yes __ Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: Assisted livin P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spe Manner of Deat 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Sigr 58303 and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSON MO 5 M 6701

State

Registrar

egistrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Marren 05:45 AM Barton May 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 □ F Days Hours 162-22-2976 82 Director Pennsylvania July 2, 1928 Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2√☐ No Director Md. Baltimore Examiner must be notified Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a 3425 Liberty Parkway 21222 USA Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🙀 No <u>ک</u> Specify: White 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Steel Worker Thomson Works 12 years Health and Mental Hygiem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren W. Barton Sr. Velma Butterbaugh ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Barton Wife 3425 Liberty Parkway, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h important: if it any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State May 18, 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 23a. Part 1. Enter the disease of complications that caused the restriction. Do not enter the mole of ying, such as carried or restriction.

23a. Part 1. Enter the disease of complications that caused the restriction. Do not enter the mole of ying, such as carried or restriction.

23a. Part 1. Enter the disease of complications that caused the restriction. Do not enter the mole of ying, such as carried or restriction. Interval Between Onset and Death Immediate Cause (Final disease or condition heart failure Congestive Physician 3 days /Medical resulting in death) Due to (or/as a consequence of): atrial fibril Examiner years Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director; After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 Pregnant at time of death 2 No 9 Unknown Records, P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Direstate 2 No 3 Probably 4 Vonknown cancer 1 TYes Completed npletely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 1 TYes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 🖺 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 6 30. Name and address of berson who completed cause of death (Item 23a) (Type, Pnnt)

Registrar

11595

State

park

4940 Eastern Avenue, Baltimore, MD, 21224

Brigham

31. Date filed (Month, Day, Year)

,M.D

32. Registrar's Signature

				For State Registrar	State of Ma	aryland	•	tificate of				Reg. No.	15859
		Physicia		1. Decedent's Name (First, Middle, La. Salvatore Joseph	,						Date of Dea Month	th 1ay ^{Day} 16, 2011	3. Time of Death
4		Medic Examin		4a. Facility Name (if not institution, give Stella Maris Du		Ley		4b. City, Town, o		n of Death		4c. County of Death Baltimo	
		Funeral Director		5. Social Security Number 6. S 218-09-5244	ex M 2 \square F	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		ler 24 Hrs. 8. I 8 Min. (Date of Birth MFth Day		nplace (State or Foreign Pyland
		nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
		Marylar 28a-fs otified	recto	MD Balti	.more	P	arkvi.	lle					1. Yes 2 □ No
ė		s 23a or 2	Funeral Director	10e. Street and Number 7009 Hamlet Ave	· .			10f. Zip Code 212 :	34			10g. Citizen of What Cou United S	-
15 a.m.	980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 A Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 🗷 Yes 2 🗆 N If Yes, Give Year or Dates.	No		Vas Decedent of Information of Information (Vas. specify Cub			Yes or No- n, etc.)	14. Race - Ameri Black, White, Specify:	
10:15	15-0	"2 hour "natu edical	plet	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	lent's Usual Occu	durina m	ost of working		16b. Kind of Business Ir	ndustry
_	212	vithin 7 jene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5-	+)		ONOTuse retired				Self-Emp	loyed
, 2011	Maryland 21215-0036	d be filed v Mental Hyg a rked oth e	To Be	17. Father's Name (First, Middle, Last) Vincent Cicero	Sr.	,				other's Name (Fir Mary Br		Maiden Surname)	
MAY 16,	, Mar	nd 2 shoul salth and n 27 is m er traum		19a. Informant's Name/Relationship (Mary Jones /Nie				g Address (Street				; City or Town, State, Zip 21204	Code)
Ž	Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ce	metery, crer	sition (Name of natory or other pla em Luthe			ay 18 011	20c. Location - City or 1 Baltimore	Town, State e, Maryland
	Balt	permit. Departi		21. Signature of Funeral Service Licen	scheme	Mols	85 22					ernatives Towson Maryl	land 21286
		nysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused one cause on each line.			er the mode of dyi	ng, such a	as cardiac or res	piratory am	est,	Approximate Interval Between Onset and Death
3	Sept.	Medical Examiner		resulting in death)	Due to (or as a								
		ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or imjury	b. Due to (or as a	conseque	ence of):						
	0	death certificate be executed the attending physician and ed for use as the burial-transit	cal Exa	that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):						,
ERO	8760	tificate ng physas the	Medical	IF FEMALE:	d								
E CICE			Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnar Other (specify)	псу			23d. Date of deli Month	very Day Year
SALVATORE	P.O.	The law requires that the dearate has been signed by the apage 2 should be detached for	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the L	nderlying cause g	given in Pa	art I.	23e. Did to	bacco use contribute to	the cause of death?
	ďs,	requires been sig should be	ted l							[1 🗆 \	res 2 No 3 □ Pro	
S	ecol	e law re e has be ge 2 sh	Completed								24a. Was a autop perfor 1 Yes	sv prior to o	opsy findings available ompletion of cause of
	al B	sician: The law certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical				26. F	Place of D	eath (Check only		2 X No 1 Yes	2 No
	Vit	Physician: this certific al director,	၉	examiner? 1 ☐ Yes 2 X No				nt 3 🗆 DOA				ence 6 X Other (Specia	HOSPICE
	Division of Vital Records,	ing Kfter uner	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	30	Year)	28b. Time of injury	M 1 L	rk? Yes 2	□ No		ow injury occurred	
	Divis	pital or Attend ours after death eral Director: / filled in by the f		4 Homicide determined	building, etc.	. (Specify)					City or Tow		
		To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exam	iner: On the basis of ex	amination	and/or inves	tigation, in my opin	nion, death	occurred at the	time, date ar	use(s) and manner as stated and place, and due to the case cause(s) and manner as s	ause(s) and manner stated
		To the within To the Communication of the Communica		29b. Signature and title of certifier	22 GRNT	0		29c. Licens	se numbe	192		29d. Date signed (Month, 5/16/7	, Day, Year)
En.	W1			30. Name and address of person who	completed cause of de				ידית	MONITIM	MD 21	1002	
b		Sta		JACKIE JONES, C 31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure A	fall	111	MONIUM,	MV 21	נצטו	
X	DHN	Registra MH 17 Rev 7/20		MALL	CUIT KER		10.1	7					
1							OPICI	NIAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1:15 AM 2011 William Robert Carter, May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 206 Robwood Road Dundalk Baltimore 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
Jul 01, 1 ▼M 2 □ F Months Davs Hours 70 Director 212-38-4826 1940 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other than the marked other than "marked". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 46 Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21222 United States 206 Robwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No 1 Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates. Victoum Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Steel Worker Beth. Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Carter, Sr. Margaret Nevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Robwood Road Dundalk, MD 21222 A. Eileen Carter /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State May Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1, Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performs this certificate 1 🗌 Yes 2 🖺 No 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? 1 🗆 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1
Yes 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗆 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 124356 ise of death (Item 23a) (Type, Print) quare Dr Ste 2200 Ballimore, MD2123 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh, g915 5-25-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death Baltimar ron If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 228-18-3219 1 ₹ M 2 □ Days Min. **Director** Yrs. 89 $8/\frac{22}{1921}$ Usual Residence of Decedent , or items 23a or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 XNo Baltimore MD Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 355 Stonewood Road 21239 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1X Never Married 2 ☐ Married 1 XYes If Yes, Give 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker ContinentalCan Be more, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be Willie Cheatham Jessie Garnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Stonewood RD Baltimore, MD 21239 Elennora Holt-Friend 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel 4 Donation 5 Other (Specify) Garrison Forest 5/25/2011 Owings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LECUTS Medical resulting in death) Due to (or as consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): its certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ vision of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Advanced this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 🗌 Yes 2 ...No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 609 2001 31. Date filed (Month, Day, Year) State 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANN MARGARET CONNOLLY 0121 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 56.1 Baltimore Med OW SOY If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 5/14/1930 1 M 2 X F MARYLAND 81 213-26-5813 Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21234 8548 WILLOW OAK ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) BALTIMORE COUNTY nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ELECTION BOARD CLERK 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ EDNA SHECKELLS CHARLES L. BARBER of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8548 WILLOW OAK ROAD BALTIMORE, MD JERRY A. CONNOLLY/HUSBAND Page 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot XX Burial 2 Cremation 3 Removal from State 5/20/2011 BALTIMORE, MD PARKWOOD CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 21286 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician disease or condition resulting in death) Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Natural Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) . CC Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31 Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David L Cas	sell		1- For State Registrar		te of Maryla		artment o rtificate o		Mental F	F	Reg. No.	2011	15863
Phys Medical Exa			1. Decedent's Nam David I							2. Date of De Month May 11, 2	Day	Year	3. Time of Death 1541 hrs
paran.			4a. Facility Name (i		give street and nu	ımber)		4b. City, Town, or L Randallstowr		h		ounty of Deat	
Fune Direct	_		5. Social Security N 220-66-6		Sex	7. Age (In yrs. i	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24Hr Hours Min	n.	irth(MM/DD	Forei	rthplace (State or gn
ÀOR		F	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limits
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te Mary	fied at	Director	10e. Street and Nur		. 51			10f. Zip Code			10g. Citizen	of What Cou	ntry?
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DIVI To the Hospital or within 24 hours after To the Fuoeral Dir	completely		one) 2 🗸	Medical Exami		f examination ar		on, in my opinion, d			and place,	and due to th	e cause(s)
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<u> </u>			Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature										
Reg	Sta jistra	~	MAY	8 2011	January St. Ret	gistrar's Signatur	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 / 1 0 7 1 1 Physician/ Julia Μ. Davey 12:54pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 213-34-9093 Days Min. Months 73 Month, Day, Yea 2 / 5 / 3 8 1 M 2X Hours **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 ☐ Yes 🗶 🛣 No 10e. Street and Number 3200 Foxglove Lane 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2XXMarried ģ Yes 2 🙀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XXNo Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72. In and Mental Hygiene.

7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Barmaid Service of and 2 should be filed wit of Health and Mental Hygie fitem 27 is marked other rother traumatic event, th Be 17. Father's Name (First, Middle, Last)
Kelly Robertson 18. Mother's Name (First, Middle, Maiden Surname) ည Josephine Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Davey / Husband 3200 Foxglove Lane, Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 5/13/2011 Baltimore MD 4 Donation 5 Other (Specify) ef Euneral Service Licensee Victor ries L. Stevens Funeral Home, 1 East Fort Avenue, Baltimore 21. Signatu Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year No by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed i 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this o 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pendina Anul 24 2011 1 Yes 2 No for 11 within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation UNKRUVY M 6 Could not be 8 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2011 O address of person who completed cause of death (Item 23a) (Type, Print) TONJON MO 6701

State Registrar 31. Date filed (Month, Day

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13, 2011 4:00 P Michael J. Dutton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Genesis Manor Care Catonsville Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min 8/21/1956 1 💢 M 2 🗆 F **Director** 54 Maryland <u>220-86-7244</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ge 1 and 2 should be filed within 72 hours after death with the nt of Health and Mental Hygiene. If then 22,5 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a Funeral 21223 USA 1506 Ramsey Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilma C. Horner George J. Dutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Ramsey Street, Baltimore, Maryland 21223 George J. Dutton / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) Loudon Park Cemetery 5/18/2011 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death JSe 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year the signed by a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s perform this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After thi funeral 28a. Date of injury (Month, Day, Year) Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 No nours after death neral Director: A filled in by the fi 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month,

Registrar

30. Name and address of

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F	Funeral Director	Г	5. Social Security No. 228-82-35	umber 510	6. Sex 1 ☐ M XX F	7. Age 5	Un yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of Bi		g	. Birthp	place (State or Foreign PA
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	th with t ms 23a must be	1204 Edgevale Road 11. Marital Status 12. Was Decedent Ever in U.S.						1.0	2091					USA			
9000	urs after dea ural", or ite	5	11. Marital Status 1 Never Marri 3 Widowed		ried Armed F	Yes 2 X No			Vas Decede f Yes, specif				cify Yes or No Rican, etc.)	No- 14. Race - Ame Black, Whith Specify: Wh:		White, e	etc.
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe Elementary/Seco	cify only highe	nt's Education est grade complete College 5+	d) (1-4 or 5+	+)	(Give i life. Di	lent's Usual kind of work O NOT use i Plan	done d retired)		st of worki	ng		ind of Busir inty G		dustry rnment
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imore	Page 1 al ment of H cant: If itel ury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)									ory	5/17		Be1t	ocation - Cit	e,	MD
Balt	permit. Depart Import any inj		21. Sign 9	ner (Service Licensee MO1539 22. Name and Address of Facility Rapp Funeral & Crema 933 Gist Ave. Silver Spring, MD 209													
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. Box 68760	that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 gnant at		death 3 🗌	Ectopic pr Other (spe		у				23d. Date o Month		ery Day Year
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of V	g Phys er this eral di	e: L o	1 ☐ Yes 2 27. Manner of Death	No 1	28a. Date	of injury	/ 2	R/Outpatien 8b. Time of		c. Injury	at		ne 5 🔀 Resi 28d. Describe			Specify)	
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	To the Hospital or within 24 hours afte To the Funeral Dire completed filled in I	Medical	(Check 2 only one) 3	☐ Medical E	Physician: To the examiner: On the bands Nurse Practioner	asis of exa	amination a	and/or invest	igation, in m	y opinio	n, death d	ccurred at	the time, date	and place	, and due to	the cau	ise(s) and manner stated.
	or with		29b. Signature and t	title of Certifier	for	m	-			License	number 64				te signed (M 6/201)		Day, Year)
D			30. Name and addre							on	DC 2	0037					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Month Day 9:11AM DING ma Medical acility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months **Director** 0090 ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) v/Seconday (0-12) Be Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surnam ဂ္ 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MO 20a. Method of Disposition b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) val Home, 10. 21. Signature deral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director, After this certificate has been signed by the attending physician and perpetieted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi-0066212 ino may 12,2011 and address of person who completed ca se of death (Item 23a) (Type, Print) Parkway, Baltimore, maryland MCClosk 201 East University 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14 2011 Pay Clifford M. Egerton 12:30om Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Days Months 1**x**□ M 2 □ F Hours February 26-1918 217 09 5793 93 Baltamere, Maryland **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9943 Perine Lane 21234 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Specify: Completed 3XX Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) Greenhouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oscar Egerton Rosalie Cole 2011 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lane Baltimore, Maryland 21234 19b. Mailing Address (Street at 9944 Perine Lane Richard Egerton (Son) Department of Health Important: If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Moreland Memorial Park Cem; May 18 2011 Baltimore Maryland 4 Donation 5 Other (Specify) permit. re of Funeral Service Dicenses Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition CORONARY ARTERY DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ner Due to (or as a consequence of): Exami burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 use as the IF FEMALE: CLIFFORD EGERTON 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2**X** No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined the Hospital a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie 2 29d. Date şigned (Month, Day, Year) Sh 10 doress of person who completed cause of death (Item 23a) (Type, Print) **JACKÍE** CRNP 2300 DULANEY VALLEY RD. JONES, TIMONIUM, MD 21093 MAY 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 7, 8, 20b, perFH, G915, 5/24/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month William Monroe Ford Physician/ 756 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year), 1931 **Funeral** 1 ₹M 2 □ F Months Hours Min. Countryland 217-26-7500 Vrs Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4286 Clydesdale Ave. 21211 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces: 1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced Specify White Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Edward Ford Jr. Mary Pauline Kenney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Brewer /Daughter 4286 Clydesdale Ave. Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematoty5/17/2011 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. NamCaremattisonFaamd Funeral Alternatives 10144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕽 Unknown onge 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed wone After this certificate 2 □ No 1 🗌 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗆 Yes ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20b&c Per FH G915 5/18/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State 15870 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Manth y Physician/ Rene Floyd Day 2011 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 6. Sex 1 ☐ M 2 🏋 F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-50-4924 Months (Month, Day, Year) 102 3.1948 62 Maryland Vrs Director Aug Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City 1 Yes 2 No Oe. Street and Number 1100 Bolton Avene 10f. Zip Code 10g. Citizen of What Country? 1008 21201 Funeral 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theron Richardson Gloria Scherer 19a. Informant's Name/Relationship (Type, Print)
Barry Floyd (Son) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1100 Bolton Avenue Baltimore, MD 21201 20b. Place of Disposition (Name of Atlantic Mixematory Baltimore Washington Grematory 20a. Method of Disposition Grencat Burtine own State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Laurel. MD 5/11/11 4 Degration 5 Other (Specify) Signar re of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 aller 23a. Part 1. Enter the disease, or complications the shock, or neart failure. List only one cause of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ysician and e burial-transit Cause (Disease or illijury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys the L attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by imonory disease 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops page 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural Accident work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 8 Registrar

DHMH 17 Rev 7/2009

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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	Medical		Medical Exa	niner: On the ba	asis of exam ner stated.	ination and/or in	vestigation, in my	pinion, death	occurred at the time	e, date and place	, and due to the ca	ause(s)
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Physician /Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f show Examiner must be notified at

'natural',

as the burial-trai ed by the attending detached for use as should be page 2 : certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

1	Due to (or as a consequence of):			
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that initiated events resulting in death) Last	c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)	23d. Date of Month	f delivery Day Year
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25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
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27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work?	d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		actory, office 28	i. Location <i>(Street and Number of City or Town, State)</i>	or Rural Route Number,
	Physician: To the best of my knowledge, death occ aminer: On the basis of examination and/or investi- and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date signed (A	Nonth, Day, Year)

D62032

5505 Hopkins Bayview Circle Balto., MD 21224

State Registrar

Jennifer

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

dress of person who completed cause of death (Item 23a) (Type, Print)

Hayashi

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Helen Clara House 2011 May 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Perry Hall Quail Run Assisted Living 8. Date of Birth Month, Day, Year, Aug. 15,1920 If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X Maryland 90 214-38-6821 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Tes 2 No Perry Hall MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 21236 United States 3900 Millner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Alice Mills Charles Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21236 3900 Millner Road Perry Hall, Maryland Alice A. Jester (Daughter) item 27 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important; If ite
any injury or ott 1 XI Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 5/17/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Buda-Ruck Fufferal Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. art 1. Enter the disease, of complications that caused shock, or heart failure. Let only one cause on each line omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Examiner nert Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna

Preanant at time of death 5 Other (specify) Ectopic pregnancy in the past 12 month Month Year Day 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) (-)5515 tea Hospital: Other: ပ္ 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

Funeral Director: A leted filled in by the fu Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F complet only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 00055171 M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltima 3023 tostern Avenue schostion KJOL-31. Date filed (Month, Day, Year) 32. Registrat's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY Physician/ Pay 2011 **EULA** HILL 5:17 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthy Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** F (Month, Day, Yea Months Director 86 230.24.9179 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City. Town or Location the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2xx No BALTIMORE MD 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 605 OLD HOME RD. 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Force ★ 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: ed other than "natural", event, the Medical Exal Completed 3 Widowed 4 XX Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 72 salth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GENERAL MOTORS ASSEMBLY LINE WORKER 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ADA MULLINS SWANSON BOGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 605 OLD HOME RD. BALTIMORE, MD 21206 CLAUDE HENSLEY 20a. Method of Disposition
1 → Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5.20.2011 POUND, VA 4 Donation 5 Other (Specify) BOGGS FAMILY CEMETERY Sig yure of Funeral Service Lice I see FINK FUNERALS HOME P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW CLEN BURNIE, MD 21061 M01148 GREGORY FINK Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to or as a consuluence of: attending physician and for use as the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No signed by the ar g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate Yes or Attending Physician: after death.

Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: <u>_</u> 1 Tes 2 XXNo 1 Inpatient 2 XXER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury XXVatural 5 Pending the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D54670 MAY 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 ROBERT GREENWALD, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2011 Registrar

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DHMH 17 Rev 7/2009

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			State Registrar				tificate of D		and Ment		g. No.		158	75
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	Exami		4a Facility Name (if not institution RADAMS CONLE	give street and numb	2/AVIVA CENTEI	2 TER	4b. City, Town, or BALTIM				4c. Cou	unty of Death		
	Funeral Director		5. Social Security Number 215-84-8105	6. Sex 1 \(\text{M} \) 2 \(\overline{\pi} \) F	. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		te of Birth onth, Day, \ ne 13	rear) 195	Cour	place (State or htry)	Foreign unk
	and show	١	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City	y Limits
	Maryl 28a-f	Director	MD			Baltim	ore						1X Yes	2 🗆 No
	with the 23a or	eral	10e. Street and Number 3314 Washingt	on Blvd			10f. Zip Code	1230		10	0g. Citizen	of What Cou	ntry?	
920	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by Funeral		12. Was Deceder Armed Force 1 Yes 2	es? 2 💢 No	If	as Decedent of His Yes, specify Cubar	spanic Ori	n, Puerto Rican,	s or No- etc.)	E	Race - Americ Black, White,	etc.	
2-0	2 hours "natur edical I	plete		nt's Education est grade completed)		16a. Decede	ent's Usual Occupa nd of work done de	tion	t of working	unk 1		of Business In	MITT	e -unk-
121	within 7 /giene. ner than t, the Me	Completed	Elementary/Seconday (0-12) unk 12th	College (1-4	or 5+)	life. DO	NOT use retired)	aning most	t or working			_		
Maryland 21215-0036	permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt. once.	To Be	17. Father's Name (First, Middle, L			diei		18. Mothe	er's Name (First,	Middle, Ma		mploye ame)		unk
Aary	should and N is ma rauma		19a. Informant's Name/Relations			19b. Mailing	Address (Street a	nd Numbe	er or Rural Route	Number, C	City or Town	n, State, Zip (Code)	
re, N	Health		University of N 20a. Method of Disposition	MD Medical		22 ace of Disposi	S. Greene	Str						
Baltimore,	Page 1 nent of ant: If i		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 🖺 Street	3 ☐ Removal from St	tate ce	metery, crema	atory`or other place		Date 7 5-25-1			on - City or To		
Balt	Departr Imports any inju		21. Sign tur of Funeral Succe L	icensee Wade, D	rector	51 Ch	sh, Crem	shior	Schwab	Witz	ke Fi	ineral	Home c	f
			23a. Part . Enter the disease, or	complications that cau	used the death.	Ba. Do not enter	the mode of dying	MD such as	cardiac or respira	atory arrest	VIII	ะริฟิลี:	21228 Approximate	
	h, sician/	10	shock or heart failure. List of Immediate Ocuse (Final disease or contion	nly one cause on each	line.						,	12	Interval Between Onset and De	een eath
	Medical Examiner		resulting in death			ence of):	ANEU1	- 14/	00				18 MK	3
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. —	EREBY as a conseque		ANEU !	2 43	79!					
	executed ian and irial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. — Due to (or	as a conseque	ance off:								
	cate be ex physician s the burial		resenting in death, East	d.	as a conseque	erice ory.								
3876	ertificate ling ph e as th	/Med	IF FEMALE:								1			
). Box 68760	or averancy Prysicians: The law requires that the death certificate be fath death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 18 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Bir 4 Pregnar 9 Unknow	th 2 🗍 Fetal on that time of de	death 3 🗌	Ectopic pregnancy Other (specify)					Date of delive Month	ery Day Ye	ar
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ecor	e law rei e has bei ge 2 sho	Completed							24	a. Was an autopsy performe			osy findings ava mpletion of cau	
a B	sician: The la certificate ha irector, page 2		25. Was case referred to medical				26. Plac	e of Death	1 [h (Check only on	⊥Yes 2	No	1 Yes	2 🗆 No	
<u> </u>	nysici this ce al direc	은	examiner? 1 X Yes 2 \(\subseteq No		oatient 2 🗆 El				rsing Home 5	,	e 6 🗆 O	ther (Specify,)	
o u	tth. : After i	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investig	9	njury 2 Day, Year)	8b. Time of injury	28c. Injury a work? M 1 🗌 Ye		- 1	scribe how	injury occı	urred		
Division of Vital Records, P.O.		I Certificate:	3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of	Injury - At hom etc. (Specify)	e, farm, stree	t, factory, office	- 'A	28f. Loc	ation (Stree or Town, S		nber or Rural	Route Number,	;
	ine nospii in 24 houi the Funera	Medical	(Check Z Medical E)	Physician: To the best caminer: On the basis o Nurse Practioner: To t	or examination a	and/or investig	ation in my opinion	death occ	curred at the time	date and r	vace and	due to the co	ico(c) and mann	er stated.
F	To:	12	29b. Signature and title of certifier	,			29c, License r	umber		29d	. Date sigr	ned (Month, E	Day, Year)	
		3	20. Name and address of person u	tho completed cause of	f dooth (lton O	Oa) /Time Dai			96147			09,	2011	
		6	SELPLE C. KLIHM B1. Date filed (Month, Day, Year) MAY 182	EN I MO	22	S. GRE	TENE ST.	BA	LTIMER	E, MI	0 2	2201		
	State Registra	e r	MAY 182	011 2. Regis	strar's Signatur	par	lad .							

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		artment of Health and Mental Hygiene 15876
Physician /Medical		2. Date of Death Month Day Year Da 14 M
Examiner	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death 4c. County of Death Baltimore City
Funeral Director	5. Social Security Number infant 0. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 17 May 6, 2011 Maryland Maryland Maryland
Maryland a-f show ied at	10a. State 10b. County 10c. City, Town or Loc	
h with the Man 23a or 28a-f sl st be notified i	10e. Street and Number 1940 Penrose Avenue	10f. Zip-Code 10g. Citizen of What Country? USA
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland th of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- I Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: black
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami To Re Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) infant 16a. Deced (Give Iife. L	lent's Usual Occupation kind of work done during most of working OO NOT use retired) infant infant infant
/lang 2 uld be filed v Mental Hygie irked other i tic event, th	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Middle, Maiden Surname) Felicia Johnson
and 2 shous auth and N n 27 is maler fraumat	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Wolfe Street Baltimore, MD 21287
ballilmore, permit. Pages 1 ar Department of Hea Important: If item: any Injury or other once.	4 Donation 5 X Other (Specify) in state	sition (Name of Date 20c. Location - City or Town, State actory or other place)
permit Depart Import any In		Anatomy Board 655 W. Baltimore Street 1timore, MD 21201 er the mode of dying, such as cardiac or respiratory arrest, Approximate
Cate be executed hysician and the burial-transit stee burial-transit steep burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	Sthal proration Interval Between Onset and Death Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)
v requires that the vergence been signed by should be detailed by Pleed by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown
The law require ate has been signate has been signage 2 should Completed		24a. Was an autopsy performed? 1
To the Hospital or Attending Physician: The law requires that the death certification is 4 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician has been signed by the attending physician in by the funeral director, page 2 should be detached for use as a Medical Certification: To Be Completed by Physician/Me	examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? M 1 Yes 2 No
ital or Attending P ars after death. ral Director: After th lled in by the funers Certification:		City or Town, State)
o the Hospi ithin 24 hou o the Funer ompletely fil	one) Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
5 3 5 8	30. Name and address of person tho completed cause of death (Item 23a) (Type, F	Res-000 May 7, 2011
State Registrar	31. Date filed (Month, Day Yes 2011 32. Registrar's Signafure	600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHNSON MELVIN Year Month Medical 05 2011 00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Baltimore N/A Funeral Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1**X**□ M 2 □ F Months Days Hours Min 241-54-2074 Director 71 5 - 1939Usual Residence of Decedent 28a-f shov aţ 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified N/A Baltimore 1 X Yes 2 ☐ No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6209 Carter Ave 21214 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Examiner 14. Race - American Indian, ō Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 2 X No If Yes, Give 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 X Divorced Specify: Year or Dates Black Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Gas & Electric Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 7th Co. N.C. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Julius Ceasar Johnson Sallie Carrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliza Baker- Sister 6209 Carter Ave. Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Donation 5 🗆 Other (Specify) King Memorial Pk. 5/21/2011 Randallstown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 1101 E. North Baltimore, MD 21202 Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final encinon Onset and Death Physician/ partec disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Exami Diabete and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Auseth. the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy After this certificate performed death? ☐ Yes 2 ☑ No 1 Yes 2 No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 \square Yes 2 🗌 No Investigation **Director:** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MD 6111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entan St Snite 308 BALTIMORE MD 21201 HOAIIS A. HA 1MH24 821 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY MAY 2011 1004 A M MILDRED **JACKSON** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL 1915 MALTRAVERS RD. GLEN BURNLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Min. Hours och Zoay, Year 1934 Country Director 213.32.7536 Usual Residence of Decedent show 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes XX No ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 USA 1915 MALTRAVERS RD. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: Specify: 3 ₩ Widowed 4 □ Divorced WHITE Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) QUALITY CONTROL PUREX CORP. 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY JULIA KEATON LUTHER ELMER CAPERTON if. Page 1 and 2 shours and Mr. and St. sm. 27 is m. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1342 HOWARD RD. GLEN BURNIE, MD 21060 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i WILLIAM JACKSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 5.20.2011 CROWNSVILLE, MD MOVETCEM CROWNSVILLE 4 Donation 5 Other (Specify) 21. Sign. Tie of Funeral Service Licen e 22 Name and Address of Facility P.A. K. GREOORY FUNK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or coshock, or heart failure. List on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final ast √Physician/ disease or condition resulting in death) YRan Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c 1 Yes 2 Tho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?

1 Yes 2 2 100 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accider injury work?
1 Yes 2 No 5 Pending Accident Investigation 24 hours after deat Funeral Director; filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calculated. Medical 29a. Certifier completed 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29505 arkan Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Glen Burnie, 305 Hospital kan Date filed (Month, Day, Year)
MAY 1 8 2011 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who co

31. Date filed (Month, Day, Year

npleted ca 5530

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wse of death (them. 2007) ype, Print) Chevy Chase, MD 20851

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vionth **Physician** Niam Kaput ZORM April ZOII /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Hopkins Bayview Baltimore, Maryland Johns Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F April, 27,2011 Director infant Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director MD Baltimore 1 ☐ Yes 2√ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 170 Orville Road 21221 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. nd 2 should be filed within 72 hours after the and Mental Hygiene. 27 Is marked other than "natural", or iter traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Samuel Bryant Nicki Kaput ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other(Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, and liture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extreme Premodurity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ы in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performe The certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Kinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 589 40 271

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

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Bayview, 4940 Earstern Are, Baltinove, mp 21224

of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KRAMER Month. 308 0755 PM Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 SF Days Hours 215-03-7947 **Director** 93 1173071917 Maryland Usual Residence of Decedent show 10a. State with the Maryland at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 ☐ Yes 2 🎇 No Maryland Baltimore Catonsville ms 23a or must be n ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Greenlow Road 21228 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes XX No If Yes, Give 3₩Widowed 4 □ Divorced 1 ☐ Yes 2 XXIo Specify Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8 Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George M. Gebhardt Lillian A. Semone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Janet Schlein-Daughter 325 Osborne Avenue Catonsville, Maryland 21228 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place oudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 105/17/2011 Baltimore, Maryland tore of Funera, S-vice Livensee 22. Name and Address of Facility l J. Weber Fdmondson Dayid 5311 Funeral Homes P.A. Avenue Baltimore, Maryland 21229 rt 1. Enter the dispase, ox ock, or heart failure. List o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ leta Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and J physician at street the burial-f resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 attending p for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 - Fetal death Pregnant at time of death Month Day Year Unknown g Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an Jas autopsy page certificate Yes 2 filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ျပ Other: this 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 1 2 Medical Examiner: On the basis of examination and/or investigation, in my pricing, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29d. Date signed (Month, Day, Year, rson who completed cause of death (Item. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ R. Mary Koermer Medical 4:00 a^M 2011 May 16 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6707 Pine Ave. Dundalk Baltimore 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year 1 □ M 2 💢 F Months Days Hours Min 216-16-5726 **Director** Maryland 87 1924 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo Maryland Baltimore Dundalk 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral the Medical Examiner must 6707 Pine Avenue 21222 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 8 years Own Home permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Martin Cross Rose Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Lou Baier Cousin 445 Westfield Road, Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May 20, 20c. Location - City or Town, State cemetery, crematory or other place) XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dundalk, Maryland Oak Lawn Cemetery 2011 Signature of Runeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, Md. 21222 or complications that caused the death. 23a. Part 1. Enter the disease Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (r as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 s 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury work?
1 Yes ☐ Accident ☐ Suicide neral Director: A 2 🗌 No Investigation 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined نا 24 hours عن**u 24 hours** عن**u the Funeral D**. completed fill Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's 5

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Holabind AUX

29d. Date signed (Month, Day, Year)

Balk MD 21222

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Day Physician/ Keene 8:25 P M Madeline 16 2011 Elmar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne's 804 Hall Road Sudlersville Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 □ M 2 🗓 F Hours 6-9-1929 (ear) 216-28-9263 Director 81 Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Severna Park MD Anne Arundel 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be Funeral 21146 19 Madary Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Owner House wife 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Firs Middle Maiden Surname) မ Madeline Weiland Carl Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 804 Hall Road, Sudlersville, MD 21668 Mrs Darlene Marks/daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Glen Burnie, MD 5/20/2011 Glen Haven Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signature of ral Service icensee M01364 421 Crain Hwy SE Glen Burnie MD 21061 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ BREAST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the funeral director, page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 2 🗌 No Yes 2 X No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's Hospital: Other: 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify this . Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 05/17/2011 D0064852 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 Dr. Ravin Garg, 2001 Medical Parkway, Wayson, Ste 201, Annapolis MD 21401 31. Date filed (Month, Day Year) 18 20 32. Regintrar's Signature State 3. parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 PerFH G916 6/16/2011 JH

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14; Physician/ 201 T Won Suh Kim 4:48 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 D F Months Days Hours Min. 10-02-1929 **Director** 201-60-4918 81 Korea Usual Residence of Decedent 28a-f shov with the Maryland Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Elkridge 1 Yes 2 No Howard 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6476 Sedgwick Street 21075 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force ö þ 1 Never Married 2 X Married Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
If item 27 is marked other than
or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sung Kim Buwon Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Jamie Joe - daughter 6124 River Road, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 Donation 5 Other (Specify) Meadowridge Mem. Park 05-17-2011 | Elkridge, Maryland 21. Sign tur of Funeral Service L 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate
Cause Eller or carlying
Cause (Disease or iinjury Due to (or as a consequence of): Exam requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No detached for Pregnant at time of death Day the Unknown g | Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 Yes 2 L No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy perform Yes 2 W No To the Hospital or Attending Physician: in 24 hours after death.

Ihe Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No ٩ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a title of certifier

State Registrar NCHARLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year,

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month av 11 2011 May William W. LaViolette 11:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bay Woods of Annapolis Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 8. Date of Birth (Month, Day, 1 X M 2 □ F Hours Min. Director 08-07-4722 1920 91 May Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 7101 Bay Front Drive 21403 **USA** within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 41-69 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the 12 administrative assistant State of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev pe William Warren LaViolette Mildred Julia Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Jay LaViolette/son 6060 Wynn Jones Road Port Orchard, OR 98366 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 Other (Specify) Signature of Funeral Service Licente State and Address of Facility Board 655 W. Baltimore Street ixector Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death vsician disease or condition resulting in death) **/ledical** (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Ito the Hospital or Attending Physician: The law requires that the death certificate be within 24 burus after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burus completed filled in by the funeral director, page 2 should be detached for use as the burus. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 NO Other 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title Clem Sole MS 20769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar IA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19asb Per III C915 5/18/2011 IIII and Mental Hygiene 2011 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Michele Denise Livingston Medical 09 2011 :00p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1898 Scaffold Way Odenton <u>Arundel</u> nne **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2**½** F (Month, Day, Year) Months Days Hours Min Director 214-78-7508 68 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a Anne Arundel Odenton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1898 Scaffold Way iral", or items? U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Center Medical College (1-4 or 5+) 12th grade 6yrs <u>System Analysis</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin Bellamy Lizzie Mae Edge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itesha Livington Daughter 1898 Scafford Way, Odenton, Md 21113 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) On-Site 5/13/2011 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final nset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year been signed by the a Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place o eath Check only one Hospital 2 No မြ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation Could not be filled in by the within 24 hours after deal To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Funeral		5. Social Security Number 215-42-7537	6. Sex 1 □ M 2 🂢 F	7. Age (In yrs.		If Under 1 Y		g. Bir	thplace (State or Foreign untry)		
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	ried Armed Fo	2 X No ∕e	It	f Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer] No Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
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imore	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 ឦ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Place of Disposemetery, cremetery	natory or other	ocation - City or odlawn,	Town, State Maryland			
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	State Registra	e ır	S1. Date filed (Month, Day, Year) NAY 18	2011	gistrar's Signa	A. A.	ake					

11-03276 Carey Michael I	_and	Please Type or Print in Black Indelible In Skroner State of Maryland / Department of Certificate of	Health and Menta			1588
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1		422 Red Tulip Court	Taneytown	Joan	Carroll	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married YArmed Forces? If Ye 2 No	Decedent of Hispanic Origin's, specify Cuban, Mexican, Po Yes 2 X No specify:		White, etc.	ican Indian, Black, hite
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, (Specify) Residence	factory, office building, etc.	28f. Location (S or Town, S Taneyto	Street and Number or Rui State) 422 Red T Own, Md.	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	ल	9a. Certifier 1	d at the time, date and place, n, in my opinion, death occurre	and due to the caus	se(s) and manner as state and place, and due to the	d. cause(s)
To vit	ě	9b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		Calmer 1	O.C.M.E.		April 30, 2011	
		Name and address of person who completed cause of death (Item 23a) Assistant Modical Examples (200 M. Pal	times Ctook Dellin	- MD 04000		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15889 Reg. No. Certificate of Death 1 - State Registra 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 201^{Year} 4:49 P. M Physician/ James Otis Lash, Sr. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Kent Chestertown Chester River Hospital Center 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Pennsylvania Days Hours 01²1²1²1²1²1²0 **Funeral** 71 212-36-5808 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2XX No traumatic event, the Medical Examiner must be notified Worton Kent 28a-f MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö United States 21678 Funeral 23a 25999 Lambs Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 12. Was Decedent Ever in U.S. 1. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: Specify: White 3altimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Year or Dates. Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Howard Community College (1-4 or 5+) College Elementary/Seconday (0-12) Engineer f and 2 should be filed with thealth and Mental Hygien tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Ruth Laura Smith မ Robert Luther Lash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25999 Lambs Meadow Rd., Worton, Maryland 21678 Valerie Lash - wife 20c. Location - City or Town, State or other 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) Department of H Important: If ite any Injury or oth 1 Burial 2XXCremation 3 Removal from State Glen Burnie, MD 05-13-2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Lic MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Stolan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical URMS Examiner duseas Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed by Dealites, chronic abstructive lung disease Be Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? nultiple cerebrouascular accidents 24a. Was an autopsy After this certificate has performed 1 Yes 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 1. Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be completed filled in by 4 Homicide determined within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check

Harry

only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

Moore

2 🗆

32. Registrar's Signature

4801

W D

O Name and address of person who completed cause of death (Item 23a) (Type, Print)

Unione

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 2<u>011</u> April 18. Joan C<u>laire Moag</u> 12:15 PMM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Chestnut Green Health Center Towson Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🔽 F Months Hours Director Illinois 337-26-3517 Ĭ933 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1055 W. Joppa Road #648 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white 3 - Widowed 4 - Divorced Specify: other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernon Swanson Josephine Plattner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code, 1055 W. Joppa Road #648 Towson, MD 21204 John A. Moag/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) injury (4 Donation 5 Other (Specify) 21. Signat re of Freeral Service On a 1 State Anatomy Board 655 W. Baltimore Street any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final filysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No
9 ☐ Unknown Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has b page 2 autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical examiner? Be сотрете filled in by the funeral director, 26. Place of Death (Check only one) 2 🕱 No မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work' Accident 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, CRNP

TOPPAROUD TOWSON

amend State of Mary 1973 5 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RACHELLE 2: Ø3 PM Di' Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HARBOR IMORE HOSPIT 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Birthplace (State or Foreign Country) Hours Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No HMON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 21 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed XX Divorced Completed lac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (4-4 or 5+) Be Father's Name (First, Middle, Last)-18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenoce. ٥ 19a. Informant's Name/Relationship (Type, Print) (5 34) 19b. Mailing Address (Stre and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licer Funerou Home, P.A. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SEVERE disease or condition resulting in death) METABOLIC ACIDOSIS Medical Examiner STAGE RENAL DISEASE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last FOCAL SEGMENTAL GLOMERULAR SCLEROSIS and this certificate has been signed by the attending physician al director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NON-ISCHEMIC CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an HIV autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier RESOOI MD 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD S. HANOVER ST SHETH 3001 1 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 13, Month 11:55 AM Geraldine 2011 Morris May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Home Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours Min. 77 (Month, Day Year) Aug 13, Director Yrs New York 122-26-5776 193B Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Brooklyn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 5215 Patrick Henry Drive 21225 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 No 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home event. Be filed Maryland 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Hogan Ethel McLeer traumatic t. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia French /Daughter permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other to once, 5609 Patrick Henry Drive Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 17 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 2011 Brooklyn Park, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Obstructive lung Didense Immediate Cause (Final Onset and Death Physician/ End STAYE Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any Iracing important cause. Enter Underlying Cause (Disease or linjury Dill to (or as a pointequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has irector, page 2 s Jas autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No ျ Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) M. Charles & Balto. M. 21204 GBIN ·A 6701 cl 32. egistrar's Signature State Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) ate of Death 3. Time of Death Physician/ WAY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner City Town, or Location of Death Baltimore Randallstown <u>Seasons Hospice</u> Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Months Days Hours Min (Month, Day, Yea -24-1924 1 X M 2 - F Yrs Director 218-18-2882 87 MD Usual Residence of Decedent 28a-f short 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director notified 1 Yes 2 X No Owings Mills MD Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ö ms 23a or must be n Funeral 21117 United States 42 Wengate Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ò 2 | No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed White WW II Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the ll years Plumber Plumbing ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Lee McCarthy, Sr. Marie Ruth Disney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health if item 27 42 Wengate Rd. Owings Mills, MD 21117 Ruby G. McCarthy (wife) other. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ō Department Important: I any Injury or Garrsion Forest Vet. 5-25-2011 Owings Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signative of Funeral Service Licenses 22. Name and Address of Facility ELINE FUNERAL HOME Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ conc disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2 🔀 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes al or Attending Physis after death. Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Year) 1 Natural 2 Accident 5 \square Pending 1 Yes 2 No Investigation completed filled in by the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practice from Total Certifying Numb (Check Cartifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 2011 Evelyn F. Mumford May 11, 7:27 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1103 Shumaker Drive #103 Salisbury Wicomico 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Director 195-05-8949 Nov 23 Year) 1914 96 Mary Tand Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Wicomico Salisbury 1 Yes 2X No ö 10e Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 1103 Shumaker Drive #103 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jennie Catherine Sullivan Ralph Everett Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 518 W. College Avenue Salisbury, MD 21804 Alan Booth/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Signat of Funeral Stryice Licenses State Anatomy Board 655 W. Baltimore Street any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause so each limit Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 plonths? 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available certificate has performed No prior to completion of cause of death?

1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital **X** No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide the 1 Investigation 1 ☐ Yes 2 ☐ No 6 Could not be within 24 hours after d To the Funeral Direct completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifyin | Nurse Practionar: | The best of my knowledge | The bes 3 Certifying Nurse Practioner: only one contented at the time, data and place, and due to the cause(s) and marrier as stated 29b 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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			For State Registrar		State	OI Waiyi		rtificate of		iu wentai n	Reg. No 2		15895
			1. Decedent's Name	(First, Middle,	Last)					2. Date of D	eath		3. Time of Death
	Physici Medi		Lee Ala	an Mill	er					Month May 9	, 2011	Year	9:40 AM ^M
	Examir		4a. Facility Name (If I	not institution,	give street and i	number)		4b. City, Town, o	r Location of I	Death	4c. Coun	ty of Death	
and a		М			on Road				Marlbo		Pri	nce G	
П	Funeral		5. Social Security Nur	mber un k 6	.Sex 1⋤M2□F		<i>yrs. last birthday)</i> 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hours		irth 7, Year 955	9. Birthp	place (State or Foreign ntry) unk
	Director		Usual Residence of D	Decedent	Λ					100 1	, 1,555		
	how		10a. State	10b. County			City, Town or Lo					-1	0d. Inside City Limits
	r 28a-f show	cto	MD	Prince	George	e's	Upper Ma	arlboro					1 □Yes 2 No
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	72 hours after death with the Maryland natural", or items 23a or 28a-f show fleat Evar, in at roughed at	Funeral Director	12441 Per	unk			110 140		772			SA	
10	after dea or items	Fun	11. Marital Status 1 □ Never Married		Armed	cedent Ever in Forces? 2 2 No	10.5.	If Yes, specify Cub	an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	IO- 14. H	ace - Americ ack, White,	
036	urs af		3 ☐ Widowed 4		If Yes, Vear or	Give		1 □Yes 2 📉 No	Specify:		Spec	ity: wh	ite
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21	within iene. than "	d d	Elementary/Second		College	(1-4or 5+)	life.	kind of work done DO NOT use retire		i working	hant	ina (A.C.
2	e filed wall Hygie other the		unk 17. Father's Name (F	irot Middle La	unk			enginee		Name (First, Middl		ing &	AC
and	ould be fi Mental I arked of atic ever	Be C	Donald		(51)					11a Sheph	•	ime)	
Maryland 21215-0036	ਵੁੱ ਰ E E	은	19a. Informant's Nan		(Type, Print)		19b Maili	ng Address (Street		or Rural Route Num		n State Zir	Code)
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Jre,	of He litem		20a. Method of Dispo			20	b. Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, State
<u>Ë</u>	Page ment ant: II ury o		1 ☐ Burial 2 ☐ 4 🔀 Donation 5	Cremation 3	☐ Removal from	n State	,, ,, ,						
Baltimore,	permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once.		21. Signature of Fund	eral Service Lo	Wedle /	pirect	011 2	Name and Addre	EST FaciliBe	oard 655 V	V. Balti	more	Street
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	Physician /Medical		Immediate Caus III disease or condition resulting in death)	[Ual	_a//	170	CARI	DIAC	11	VFARC	-710W		
-	Examiner		3 ,		Due t	o (or as a con	sequence of):	\ A	RIO	DY	MICE	asp.	Years
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ς, σ.	uires that the de signed by the a d be detached t		Part II. Other signific	ant conditions	s contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	ne cause of death?
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ecc	ne law require has been si ge 2 should b	plet								24a. Wa	s an 24b	. Were auto	psy findings available mpletion of cause of
<u>=</u>	ding Physician: The In. After this certificate his funeral director, page	Con								per	formed? 2 🗆 No	death?	2 □ No
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	s afte	Certification: To	4 🗆 Homicide		Duli	ding, etc. (Sp	есну)			City or To	own, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 (Check only 2	Certifying Medical Ex	Physician: To t	he best of my	knowledge, deat	h occurred at the ti	me, date and	place, and due to the	e cause(s) and	manner as s	stated.
	the h	Medical	onej		and ma	nner stated.				oodii oo at tio tiint			
	5. ½ € §		29b. Signature and tit		APP	alo.	4	29c. Licens	e number	56	29d. Date sign	iea (Month,	∪ay, rear)
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			30. Name and address Allen	7 Obo	Cr - /C	301 (corgia	Ave #	101 Si	lver Spr	ing n	10	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McCloud Hill Month lacqueline 8:10A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dell Lourt Baltimore Battimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 215.57.1275 Hours Manth, Day, Year) Country) Yrs MD Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 28a-f Baltimore 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 21244 USA 1 Dell Court items ; 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Securty Admin. 12th glade Associate Deputy Comm 2 years Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harris Keed, Evelun Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbe - Rural Route Number, City or Town, State, Zip Code) McCloud /Husband amont Court Battimore MD 21244 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Greenmount Crematine 05 18 201 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Pacility Vaughor C. Greene Fyneral Services Vauga Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph_sician/ mekstable disease or condition resulting in death) 6 montes Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 1 Yes 2 🗌 No Yes 25. Was case referred to medical the Hospital or Attending Physician; funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 743386 5-17-2011 SN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Duniel Ballimore Howard 1714 Place 31. Date filed (Month, Day Year) 32, Registrar's Signature State Registrar

McCloud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ dna A SU 10.20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Good Samaritan Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 ¬F Months 1907 Maryland **Director** 103 212-28-9642 December Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Tes 2 No Baltimore <u>Ma</u>ryland Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? USA be r items 23a Funeral 21234 3122 Woodhome Avenue and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 sy No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the A once. Men's Clothing Unknown Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Louise W. Helmker ဂ္ Louise William D. Wroten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Rossville Blvd. Room 330 Baltimore, Md. 21236 <u>Kathryn Amorose/ Friend</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Maryland 5/13/11 Parkwood Cemetery Signature of Funeral Service Licensee 5305 Harford Road 22. Name and Address of Facility

Leonard J. Ruck Inc. Baltimore Md. 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ce of) Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death by the Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 2 X No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No မ 24 hours after death.

Funeral Director: After this leted filled in by the funeral dil 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

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completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, -17-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da State 18 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 902 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 63 Director 214-44-7160 July 3,1947 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Director 1XXYes 2 □ No Baltimore City Baltimore 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? "natural", or items 23a or 21222 6535 St. Helena Avenue Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1X Yes 2 [If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify <u>ک</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years <u>Aerial Photography</u> Maps Inc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward McIlhenney Julia Frances Marpoe ည 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6535 St. Helena Ave. Baltimore, Maryland Mrs. Mary Lou McIlhenney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 5/17/2011 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) rears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specity) 2 🗌 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 ∏ Yes 2 NO 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home 2 R/Outpatient 3 DOA မ 5 \square Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 🗌 Yes 2 □ No 3
Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a 29a. Certifier 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0028384 May 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 essmar 31. Date filed (Month, Day, Year) MAY 18 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deced nt's Name (First, Middle, Last) 2/Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Randallstown Seasons Hospice of Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours (Month, Day, Year) Sep 3, 1931 Yrs **Director** 218-26-6459 79 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 ☐ No Randallstown Maryland Baltimore 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9117 Sunset Ridge Road 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian. Black, White, etc. 0 چ 1 Never Married 2 X Married Yes Yes, Give 2 No 3altimore, Maryland 21215-0036 within 72 hours after 1955 1 Yes 2 X No Specify: "natural", Black Completed 3 Widowed 4 Divorced Year or Dates 1957 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Charlton Brothers Trucking Driver traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ...ylic ...ye 1 and 2 should be) ...opartment of Health and Mental. Important If item 27 is mart any injury or other. ೨ Bessie Morris Mason Harold Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9117 Sunset Ridge Road Randallstown, Maryland 21133 Linda Mason 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 05/18/11 Owings Mills, Md. 4 Donation 5 Q Other (Specify) Garrison Forest Veterans Cemetery 21. Si nature Feral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each rval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year the Unknown g 🔲 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably Completed **Z** Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page perform this certificate Yes 2 No 2 🗌 No ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes nours after death neral Director; A ifilled in by the fi M 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

29b. Signature and title of certifier

18

Office 31. Date filed (Month, Day,

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Benito William Miller 2011 15900 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Month **Medical Examiner** BENITO WILLIAM MILLER 1015 hrs May 5, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 77 Magothy Beach Road Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Hours Country) MD 213.64.1301 1 XXM 2 F 55 OCT 20, 1955 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 XX No Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene.

181: If item 27 is marked offer them "sections!" ANNE ARUNDEL **PASADENA** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 47 MAGOTHY BEACH RD. 21122 or items 23a Funera 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 XX Never Married 2 Married White, etc. 1 Yes 2XX No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify: event, the Medical Examiner Specify BI ACK 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 **BOILERMAN** AA CO SCHOOLS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be JOHN ALBERT MILLER ELIZABETH HOWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESTER ANDREW THOMPSON 2570 CLAREMONT RD. REMBERT, SC. 29128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State permit. Pages
Department of
Important: I BAYVIEW CREMATORY, INC 5.12.2011 BALTIMORE, MD 21. Signature of Funeral Service Lice minny 22. Name and Address of Facility
FINK FUNERAL HOME. K. CRECORY FINK M01148-426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart **Physician** Approximate Interval cause of each line een Onset and /Medical Death Immediate Cause (Final disease Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ician/Medical ☐ AMENDED **23a,pt.II,27,per me,g916 6-9-11 sm** attending physician or use as the burial -X UNPENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? page ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this DOA 1 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 24 hours after death. Pending 1 Yes 2 No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 _ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 6, 2011 30. Name and address of person who completed cause of death (item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)
NAY 18 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per FH G915 5/19/2011 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14, Physician/ Month 12:40 RM 2011 Lee Vita Novak May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) 6, Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏋 F Days Min. Feb 24, Year) 1921 Director 90 Yrs. Maryland 215-18-5917 Usual Residence of Decedent 10a. State 10b. County the Maryland Ħ 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f s notified MD Baltimore Towson 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code ems 23a or 10g. Citizen of What Country? Funeral 7925 York Road 21204 United States items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner ō Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ဂ္ Joseph Chiaramonte traumatic Anna Parrinello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a: If item 27 is Chris Novak /Daughter P.O. Box 705 Monterey, MA 01245 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9 May 16 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last and -trang Due to (or as a consequence of) physician the burial Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available 24a. Was an has page 2 autopsy performed? Yes 2 No prior to completion of cause of death?

1
Yes 2
No

death certificate be executed P.O. Box 68760 Hospital or Attending Physician: The law requires that the Division of Vital Records, this certificate funeral director,

Maryland 21215-0036

Baltimore,

Be မ Certificate:

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 W/No Other: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

RALTIMORE MD

21201

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUBY ARAT NORTH CHARLE 31. Date filed (Month, Day, Year)

32. Regisfrar's Signature

DHMH 17 Rev 7/2009

State Registrar

s after death. the 1

24 hours a

within 2 To the F

completed filled in by

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOBLE Month ONNIE (1) Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Feb. 18 Months Days Min. 1 🗆 M 2 🗷 Year) 1944 Washington D.C Director 213-42-9952 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 963 Fall Circle Way 21054 United States items ? within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Armed Forces? Yes 2XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. White "natural", Completed 3 X Widowed 4 ☐ Divorced Specify event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant: If item 27 is marked other njury or other traumatic event, t Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Francis Baxter, Sr. Elizabeth Downes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie Noble / Daughter 343 Hidden Farm Dr., Exton, PA 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otf cemetery, crematory or other place)
Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 05/16/2011 Beltsville, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD MO15391 WS 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Dead+ a disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 Yes 2 No signed by the be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an . Were autopsy findings available prior to completion of cause of this certificate has page 2 autonsy perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending Accident 1 Tes 2 🗌 No within 24 hours after death To the Funeral Director: the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ignature and title Date signed (Month, Day, Year) 21438 2011 Name and address of page on who completed cause of death (Item 23a) (Type, Print

Registrar
DHMH 17 Rev 7/2009

State

ICHAEL

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 915 5-23-11 vt

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 3. Time of Death Physician/ Month May WAI NG 2011 8:00 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Watts Assisted Living Severn Anne Arundel . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) China 1 - M 2 X F Min. Months Days Hours July 26, Year) 1925 144-46-4524 85 **Director** Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitified at any injury or other traumatic event, the Medical Examiner must be notified as 10a State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1445 Watts Avenue 21144 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes all If Yes, Give Baltimore, Maryland 21215-0036 2**XX**No 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced Specify: Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ng (Son) Severn, MD 21144 7810 Poplar Grove Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 5/13/11 Elkridge, Signa of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc 7250 Washington Blvd., Elkridge, MD 2107 Approx 23a. Part 1. Engle the disease, or complications that can shock, or peart failure. List only one cause on each Immediate Cause (Final Approximate Interval Between set and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a conequence of Examiner Par Sequentially list conditions, if a y, leading to innuclate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to for sele consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has [performed Yes 2 🖼 1 🗌 Yes 2 DNO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔄 No Other: 1 Tyes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) ho completed dause of death Item 23a) (Type, Print) MD 0 h 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Douglas G. Outerbridge 12:00 pM Medical May 14 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1**x** M 2 □ F Months Days Hours (Month, Day, Year) Director 216-14-3223 91 September 3.1919 New York Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location 10d, Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1933 Pennhall Road 21222 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 of Health and Mental Hygiene. Item 27 is marked other than "natural", 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintance Mechanic Machine Craft Inc. <u>8 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Outerbridge Mary Rambo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Long Daughter 116 German Hill Road, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 16, cemetery, crematory or other place) Bayview Crematory Baltimore, Maryland 2011 Signature of Funeral Service Licens 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or complications that caused the death. 23a. Part 1. Enter the disease, o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or imjury for use as the burial-trans been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de th? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an the funeral director, page 2 autopsy performed death? this certificate 2 No Yes Vital 25. Was case referred to examiner? medical Be 26. Place of Death (Check only one) 1 🗆 Yeş 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manor of Death 28a. Date of injury (Month, Day, Year) ivision of Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending Natural 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 To the Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:45# Paune Albetha Elizabeth Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PG Cheverly, Huspital P6 cente Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** g. Birthplace (State or Foreign 1 🗆 M 2 🕻 F 579-26-0796 12/13/1925 Country) Director VA Usual Residence of Decedent 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f Prince George's MD Hyattsville 1 🗌 Yes 2 💂 No 10e. Street and Number 10g. Citizen of What Country? USA ö 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be by Funeral 20784 6715 Newport Road Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 217 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates **Black** 1 Yes 21 No Specify 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Non-Profit Community Organizer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albertha Geneva Smith ပ James E. Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 6715 Newport Rd. Hyattsville, MD 20784 Timothy Warren, son other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 5/18/2011 Beltsville, MD M01539 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day n signed by the aid be detached f 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law in 24 hours after death.

le Funeral Director, After this certificate has be letted filled in by the funeral director, page 2 s autopsy perform Yes 2 🗌 No Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other 1 🗌 Yes ဂ္ ppatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2
To the I To the only one) 29b. Signature and title of certifier 29c. License number of person who completed cause of death

State Registrar

ORIGINAL

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. AMEND ITEM#8perFH, G916, 6/8/2011, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician 5/12/2011 3:50 AM /Medical John H. Perry 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Catonsville Baltimore Frederick Villa Nursing Home 8. Date of Birth **1927**(Month, Day, Year)
3/24/2011 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Davs 1**X** M 2□ F Months 245-20-6136 84 Ν Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 □Yes X□ No Director Baltimore MD Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3600 W. Franklin St. Apt. 9 A 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify: ð Specify: ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Center Club Waiter 10th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Deller Webb Silas Perry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. Archie Perry- Nephew 8212 Edwill Ave. Baltimore, MD 21237 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park 5/17/2011 Arbutus, MD 22. Name and Address of Facility March $\ F/H\ 1101\ E.$ North Ave. Baltimore, MD 2120221. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the der h. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed Due to (or as a consequence of) physician a s the burial-1 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed certificate 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No Medical Certification: To s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Catarsville URAKHIA MY 1009

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAY 18 2011

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May 10ay 2011 Year Physician/ 0730 Janet C. Pannel 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll New Windsor 3620 Hooper Rd. Birthplace (State or Foreign Country) MS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Days 1 M 2XX F Months Hours May 7 Day 1936 412-54-0552 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Tes 2XX No **NEW WINDSOR** CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 3620 HOOPER RD. 21746 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces ò 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant; If item 27 is marked o ၉ RUTH LUNA ROBERT C. CARSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 HOOPER RD. NEW WINDSOR, MD 21746 SARAH ELLEN SNYDER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 XX urial 2 Cremation 3XX Removal from State GLENFIELD CEMETERY 5.18.2011 NEW ALBANY, MS 4 Donation 5 Other (Specify) K. CRECORY EVIK 22. Name and Address of Facility P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW CLEN BURNIE, MD 21061 M01148 23a. Part 1. Enter the disease, shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerobhovascular Privitic land disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ANC TOPE been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No Day Year Month Pregnant at time of death 1 ☐ Yes ∠ 40 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖊 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 XXNo 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XX Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature-en title of certific MAY 15, 2011

Registrar

DHMH 17 Rev 7/2009

State

349 MALCOLM DRIVE WESTMINSTER, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RAYMOND KANERIA, MD

18 2011

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ MILDRE Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TUWN 7. Age (In yrs. last birthday) If Unde 4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F 2 Months Days Country) **Director** Yrs ennes 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 ☐ No nmo 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No ģ 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 ☑ No Specify "natural", Completed 3 ₩idowed 4 ☐ Divorced Bla Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🎣 🎎 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Barbara 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) uneval Home P. 21. Signature of Funeral Service Zicensee North 23a. Part 1. Enter the dise and or complications the shock, or heart failure. List only one cause on ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ neumon Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): and -transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician at for use as the burial-Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death?

1 Yes 2 No autopsy performe Yes To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 17 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 11th (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) 1dara un 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kusso Toi I HN 0818 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** g. Birthplace (State or Foreign 1 M 2 □ F Days Hours Min Months Director New York 577-52-5213 [938 June Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 318 Kingsberry Drive 21409 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 Divorced white Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)
5+ physician healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vito Russo Helen Elizabeth White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Russo/spouse 318 Kingsberry Drive Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Qther (Specify) 21. Signatur of Euner & Service Licensee Rona S Wade State Anatomy Board Baltimore, MD 21201 rector 655 W. Baltimore Street 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and defeached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 2 🗆 No Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ٩ 2-1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? injury 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 ∐ 3 □ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) er cha Name and address of person who completed cause of death (Item 23a) (Type, Print) J-191 ENTAIM 445 DEFENSE NNAPOUS MO 2140 31. Date filed (Month, Day, Year) State Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2 Registrar	State of per me	Marylan g916, 0	6/03/2 Cer	rtment 011dh <i>tificate</i>	of Hea of Dea	ilth and ath	Mental Hy	giene, Reg. No.	2011	15911
1. Decedent's Name (First, Middle, Last) Physician/ Medical John Rosborough								2. Date of De Month	ath	Z ^{Year}	3. Time of Death 5 02 A M		
	Examir						4b. City, Town, or Location of Death Baltimove 4c. County of Death						
	Funeral Director		5. Social Security Number 251-44-9648 6. Sex 1 № 1 № 1 № 1 № 1 № 1 № 1 № 1 № 1 № 1 №				If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 28 , 1932					9. Bi 32 Sou	rthplace (State or Foreign
	yland f show	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits
	the Mar or 28a oe notifi	Il Director	MD 10e. Street and Number			Balt	10f. Zip C			T	10g. Citiz	zen of What C	1 🌠 Yes 2 □ No ountry?
:	ath with ems 23; cmust b	Funeral	3717 Nortonia	Road 12. Was Deced	ant Ever in II 9	112 14	las Dacadar	21216		Specify Yes or No-		USA	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? 2 🕅 No	lf 1	Yes, specify Yes 2	∕Cuban, Me	exican, Pue	to Rican, etc.)		4. Race - Ame Black, Whit Specify:	
Maryland 21215-0036		e Completed			(Give k	Jent's Usual Occupation kind of work done during most of working O NOT use retired) steel worker					16b. Kind of Business Industry Bethlehem Steel		
/land		To Be	17. Father's Name (First, Middle, Last Marshall Rosbor	,				- 1		ame (First, Middle, e Bell M		,	
, Mar.			19a. Informant's Name/Relationship Tiffany Rosboro							ural Route Numbe e Severn		own, State, Zi 21144	
OE .	ment of Heal ant: If item ; ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Spe			lace of Dispos emetery, cremi				Date	20c. Loc	cation - City or	Town, State
Balt	Departn Departn Imports any inju		21. Signatur - Funeral Service Lice	Wate, Vi	rector		Nere and Ltimor			d 655 W. 01	Balt	imore	Street
P	rysician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	ed the death. Do not enter the mode of dying, such as cardiac or respiratory arr							Approximate Interval Between Onset and Death Z Min
	xaminer	<u>۲</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events					Pamilia Authority Medical CERTIFICATION APPROVED BY MEDICAL FOR Dr.					5 Min
inted	been signed by the attending physician and should be detached for use as the burial-transit	Examiner											
60 ate be exe		edical E	resulting in death) Last	Due to (or	as a conseque	ence of):			PAGMEL	TION APPROVED BY	3.7	tus	
DIVISION OF VITAL RECORDS, P.O. BOX 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed.	/ the attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗍 Fetal nt at time of de	death 3 🗌	Ectopic pre Other (speci	gnancy				3d. Date of de Month	livery Day Year
s, P.O.	signed by be deta	by Pi	Part II. Other significant conditions	contributing to dear	th but not resu	Iting in the un	derlying cau	se given in	Part I.				the cause of death?
DIVISION OT VITAI RECORDS, tal or Attending Physician: The law requires	as been : 2 should	pletec	Lung cancer		-					24a. Was a	an	24b. Were au	robably 4 Unknown topsy findings available
M Ke	ificate ha or, page	Be Com	25. Was case referred to medical					26 Place of	Death (Chr		med?	death?	s 2 No
7 VITS Physicia	this cer ral direct	卢	examiner? 1 Layes 2 No- 27. Manner of Death	Hospital: 1 Inp	patient 2 🗆 E	R/Outpatient 28b. Time of	3 🗌 DOA	Other: 4 [Home 5 Resid			ify)
ION O	leath. tor; After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month,	Day, Year)	injury	28c. Injury at work? M 1 Yes 2 No			28d. Describe he	how injury occurred		
UIVIS Ital or At	within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)				t, factory, office 28f. Location (\$ City or Tow			Street and Number or Rural Route Number, vn, State)			
he Hosp		Medical	(Check 2 - Medical Exan	niner: On the basis o	of examination a	and/or investig	ation. in my	red at the time, date and place, and due to the caus on, in my opinion, death occurred at the time, date and occurred at the time, date and place, and due to the			nd place, and due to the cause(s) and manner stated		
29b. Signature and title of certifier 29c. License number							per	29d. Date signed (Month, Day, Year) May 9, 2011					
			30. Name and address of person who	completed cause o			nt)	-	Διακ	J. William			
	State Registra	7	B1. Date filed (Month, Day, Year) MAY 1 8 201	32. Regi	Saltimo strar's Signatur	re face	10	U L	Am	y Hwan	7,100	ν	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Randall Dav **Physician** Month Year Ora 0859 AM 2011 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Randallstown Kandalls town Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 ₽ Director 314-54-3953 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f show must be notified at 1 Dres 2 No Director imore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö items 23a 21215 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. SQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UnKnown ပ 19a. Informant's Name/Relationship (Type. Pring 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 3509 Baltimore, MD 81215 Edge dad 20b. Place of Disposition (Narbe of cemetery, crematory or other 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 6-2011 land 21. Signature of Futeral Service Lice . Greene Puneral Services avokn C Road an //stown mu 21133 23a. Part1. Enjerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Corona A

Due to (or as a consequence of): Artery disease /Medical Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Hypothy roidis m
Due to (or as a consequence of): burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical betes the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Chronic diseas 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Barrett 1∐ Yes 2 🔀 No To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗷 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May D71493 116/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bozor Farah 91091 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) May **Physician** 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 56 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with r items 23a or ner must be r 21224 USA Orleans 2616 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. 11. Marital Status Armed Forces

1 Yes 2 item 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner 1 Never Married 2 Married 2 No 21215-0036 1 Yes Black Specify: ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) on solidated CB Richard Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Robertson Dhirler ၉ 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephanie R Health a Balto, MD 21224 2616 Orleans Department of Heali Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 🗌 Burial 2 Crem Ballimore, MD 5-23-2011 4 Donation 21. Signature of Fune I Selvice March F/H Baltimore, MD procedions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause is each line. Approximate 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any local light in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 - Ectopic pregnancy Year Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 **♥** Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 1 Tyes Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner?
1 X Yes 2 No Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA 6 Other (Specify) မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 🗌 No ours after death.

leral Director: Af

filled in by the fu Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medical and manner stated 29d. Date signed (Month, Day, Year) Signatur 29b 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Si

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Yeer Month **Physician** 10:00 AM^M 3, 2011 May John Stose /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Odenton 1119 Colony Ridge Road 8. Date of Birth (Month, Day, Year) May 17, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours Pennsylvania 1 X M 2 □ F Yrs. 1927 83 211-14-8037 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is ast be mufflied at once. 1 ☐ Yes 2√☐ No Director Odenton Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 1119 Colony Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced un Completed 16b. Kind of Business/Industry 16a. Decerlent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Hughes John Stose Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1119 Colony Ridge Road Odenton, MD Jane Stose/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Stryice Licen and Strying Str 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street irector 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of the cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months? 1 □Yes 2 □ No ed by the 9 D Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signled (Month/Day, Year) 29c. License number 29b. Signature and title of Name and add

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Physician/ ")UeRS MARIANNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 244 Carroll Road Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Min. oct 9, 1940 Maryland Director 70 214-38-2935 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2x No MD Anne Arundel Pasadena ms 23a or must be n ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 244 Carroll Road 21122 USA items death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. "natural" Completed Specify: white 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) supervisor event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) alth and Mental H ၉ Earl Williams Stivers Sr Iona June Thomson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 4134 Brookfield Avenue Nottingham, MD 21236 Robin Baker/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 🖺 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) S. Warte Rivineral Service 3 Parend Afferto My Will Board 655 W. Baltimore Street Director 21201 Baltimore, MD Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ma disease or condition Medical resulting in death) Due to (o equence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Month Year Pregnant at time of death signed by the a b Hospital or Attending Physician: The law requires that the 24 hours after death.
b Funeral Director. After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform ☐ Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 000 ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Vatural 5 Pending work? 2 🗌 No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type,

Day,

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 shenmar Ci Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice/Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 2. 1917 1 🗶 M 2 🗆 F Min. Hours Mary Land 93 Director 186-05-6026 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 1 Funeral 2 Gyer Ridge Court #3722 21216 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 X Never Married 2 ☐ Married 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify white Completed 3 Widowed 4 Divorced 143-46 Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) home improvement 10 painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o 2 Edna Blanche Moore Myron Clark Sherman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Robert Farley/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 28 Hareand Adda to the lit Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Inter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of leart failure. List only one cause on each line. Approximate Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 🗆 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page certificate Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending work? Matural injury 5 Pending death. 2 🗆 No 2 Accident
3 Suicide after death

Director: A

I in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore.

Box 68760

P.0.

Records,

Division of Vital

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 00.52 AM Subhan 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral №** M 2 🗆 F Days Months **Director** <u> 213-89-05</u>16 17 2010 MD Usual Residence of Decedent fshow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f sho miner must be notified at Director 1 ☐ Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21043 U.S.A. 8644 Town and Country Blvd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. is marked other than "natural", or ite Examiner 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify \$ 3 Widowed 4 Divorced Specily: Asian Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rukhsana Bibi မ Muhammad Shafique 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8644 Town and Country Blvd, Ellicott City 19a. Informant's Name/Relationship (Type. Print) t of Health 8644 Town and Country Blvd, <u>Muhammad Shafique-Father</u> or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 5 Other (Specify) Donation King Memorial Park 5/16/2011 Woodlawn, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Sia tur uneral Service Licensee once 21215 Enter the disease, or complications that caused to complete the cause on each line. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shod Interval Between Onset and Death Immediate Cause (Final **Physician** Cordio - respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Multisystem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit uncertain and resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specily) Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed' Yes 2 No 1 TYes 2 No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 \square DOA မ 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 051 14/2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CORINA NO 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 'arv 100 12:25PM **Physician** 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours Min. 1 M 2 F 212-42-4143 65 Dec. 30,1945 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ms 23a or 28a-f sho must be notified at 1 ☐ Yes 2X No Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21222 United States 3306 Wallford Drive Funeral ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Baltimore County (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools <u>Instructional Assistant</u> 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joan Smith Arden Koski မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21222 7838 Charlesmont Road Dundalk, Maryland Trisha Pumphrey (Daughter) 27 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Mem. Park 5/19/2011 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. re of Funeral Service Licensee 21. Si 7922 Wise Ave. Dundalk, Maryland Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a confequence of): artem /Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 X Inpatient မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury or Attending Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res - 000 May 4,2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASHNA GINWALLA MD 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) park State Registrar

X DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #5 Per FH G915 5/19/2011 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Scott Betty May 14. 2011 11:30p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care North Point Baltimore Dundalk 226-38-5388 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min (Month, Day, **Director** January 17. Virginia Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Completed by Funeral Director Baltimore Md. Dundalk 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 252 Saint Helena Ave. 21222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2x No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 5 years Nurse Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Monroe Conley Lyda Ruth Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Scott Son 320 1/2 South Second St. Oakland, Md. 21550 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date 7, cemetery, crematory or other place) 1 🗆 Burial 2x Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 2011 21. Signatur Fineral Service in see 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 23a Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each inc. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ AKNIOVASCULAR DISEASE ELOSCLEROTIC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to infinitellate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a fer death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and deed be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No Yes Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🔲 Pending work 1 Tes 2 No 2 Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOOG0560 an Idola ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person PHILANGLPHIA ROAD #208 ROGEDALE. 9106. 32. Registrar's State Registrar

11-03416 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles Richard Shuff 1- For State Certificate of Death Reg. No. Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 6, 2011 Charles Richard Shuff **Medical Examiner** 0748 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 114 Palmetto Drive Edgewood Harford 5. Social Security Number 2 1 9 – 3 5 – 0 5 0 5 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 37 05/04/1974 $_{1}X_{]M}$ MD 2 F Country) Usual Residence of Decedent Ob. County IOc. City, Town or Location 10d. Inside City Limits MD Howard Elkridge 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6636 Washington Blvd Lot11 21075 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes 2 White 1 Yes 2 No specify: If Yes, Giva Year 4 Divorced þ 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9yrs College (1-4 or 5+) Construction General Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Lee Misner Be James Shuff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6636 Washington Blvd Lot11 Elkridge MD Mista Dawn Horn Daughter 20a. Method of Disposition
1 Burial 2 A Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State At Tant tite place em 05/9/2011 Glen Burnie MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Simplicity Crem & Fun Serv 21 Service Lice ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, pt.II, 27, per me, g916 6-10-11 sm X UNPENDED has been signed by the attending physician a 2 should be detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Day 1 Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of Liver Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed' death? page ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural neral Director: A 5 Pending 1 Yes 2 No Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 7, 2011

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

variante

Margarita Korell MD. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Momas Month Medical 5:00 PM 2001 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Pineview Clinton Prince Social Security Number George's **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Director 1 🕅 M 2 🗆 F Months Days <u> 242-38-3520</u> Oct 26, 1927 83 South Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Clinton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 Pineview Lane 20735 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc 3 🛛 Widowed 4 🗌 Divorced 1 ☐ Yes 2 🕅 No Specify: black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) unk 16b. Kind of Business Industry unk Elementary/Seconday (0-12) College (1-4 or 5+) 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jordan Thomas Rachel Brevard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Curry/cousin 4320 Eileen Court Woodbridge, VA 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗶 Other (Specify) in state Signature of Funeral Service Lice Stare and Address of Facili Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Seter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or 1 of failure. List only one cause on each line. Approximate Immediate Cause Interval Between Onset and Death Physician/ disease or condition resulting in death) rostate Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leadin, to immediat cause. Enter Underlying Cause (Disease or iinjury Directo (or se a consequence of). ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 signed by the attending de be detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Beath 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 No Month Day Year 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 2 🗷 No မ 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 1 Tes 2 🗌 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner. On the basis of examination and investigation, firmly opinion, death occurred at the time, date and place, and due to the cause(s). Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person with completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

8

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 10, Physician/ 2011 9:00 PMM Lois D. Weeks Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore 8. Date of Birth

(Month, Day, Year)

Dec 14, 1940 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F ^CMaryland Director 70 215-40-1018 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2x ☐ No MD Anne Arundel Pasadena 10e, Street and Number 10g. Citizen of What Country? should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a o Funeral 21122 USA 54 Magothy Beach Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify. white Specify: Completed 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 auction gallery catalog typist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Eleanor Leather Newton E. Clarke permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7974 DelHaven Avenue Pasadena, MD 21122 Dane Weeks/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ★ Other (Specify) in state Signature of Funeral Service State and Andress of Facility and 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the deshow, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or conditions) Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Completed by Physician/Medical Examine cause. Enter Underlying Due to (or se a consequence of) Cause (Disease or iinjury that initiated events physician and the burial-trans Due to (or as a consequence of) resulting in death) Last led by the attending physician detached for use as the buria IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown P.O. Part II. Oth significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor: After this certificate has been signed the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 nknown 4b. Were autopsy findings available prior to completion of cause of or Attending Physician: The law autopsy perform deatha Yes 2 2 No Division of Vital 25. Was case referred to m To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manney f Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 1 atural 5 Pending 24 hours after death Funeral Director: A 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 30. N State Registrar

			Please	e Type or Print in			-			
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No 1 5 2 3									
			Registrar 1. Decedent's Name (First, Middle, La	st)	Certifica	te or Death	2. Date of Death	eg. No.		
	Physicia Medic	al	Irma L.	Taylor	Luca	-	May 1	6,201 1:15 PM		
	Examin	er	4a. Facility Name (if not institution, giv 4632 Rokeby	Road	4b. Cit	y, Town, or Location of Death	1 	4c. County of Death		
	Funeral Director	100	5. Social Security Number 235-34-5381 Usual Residence of Decedent	Sex 1 □ M 2 S /F 7. Age (In yrs.	last birthday) If Und Yrs. Months	ler 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		
	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e	Director	10a. State 10b. County	10c. C	Baltin	nore.		10d. Inside City Limits 1 ☑ es 2 ☐ No		
	ith the N 23a or 2 st be no	ral Di	10e. Street and Number	0.4		21229	1	0g. Citizen of What Country?		
	items	Funeral	4632 KoKeb	12. Was Decedent Ever in U Armed Forces?		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,		
9003	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 🐱 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1	2 No Specify:	o nicari, etc.,	Black, White, etc. Specify: Black		
215-(n 72 ho an "nat Medica	Completed	15. Decedent's (Specify only highest g	rade completed)	16a. Decedent's Us (Give kind of w life. DO NOT u	ork done during most of wor	king	16b. Kind of Business Industry		
121	filed within 72 al Hygiene. I other than ' vent, the Me	Be Co		College (1-4 or 5+)	<u></u>	PN		Health Care		
Baltimore, Maryland 21215-0036	should be filed and Mental Hy 7 is marked oth raumatic event	To B	John Henry	y Wood		18. Mother's Nar	He T	aiden Suname) Ay IOT		
, Mar	nd 2 shou ealth and m 27 is m eer traum:		19a Informant's Name/Relationship Elias C. Tay	F	19b. Mailing Address	ss (Stipet and Number of Ru o Keby Rd	ral Route Number, Pal+	city or Town, State, Zip Code) 0., OND 21229		
nore	age 1 a ent of H nt: If ite y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Spec	Removal from State	Place of Disposition (Na cemetery, crematory or	other place)	1.	20c. Location - City or Town, State Owings Mills, MD		
Baltir	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.	23	21. Signature of Funeral Service Licer			and Address of Pacilit 6	26-11 (sene far	eral Services (21229)		
ı			23a. Part 1. Enter the disease, or con shock, or hear failure. List only	1 - 000,000						
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a CVA	5/1/20			Onset and Death		
	Examiner			Due to (or as a consec	quence of):	diseale	_			
	sit sit	Examiner	Sequentially list conditions, far y background to the cause. Enter Underlying Cause (Disease or injury Cause (Disease (Di							
	be executed sician and burial-transit	I Exa	Cause (Disease or iinjury that initiated events resulting in death) Last c. Due to (or as I consequence of):							
092	cate be ex physician the burial	edical		d						
Box 6876	th certific ttending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?	23c. If yes, outcome of pregn	tal death 3 🗌 Ectopic			23d. Date of delivery		
). Bo	the deal	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 Other (/specify)		Month Day Year		
Division of Vital Records, P.O.	s the	by	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	g cause given in Part I.		es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
cord	aw requasi been 2 shoul	Completed					24a. Was an			
Re	I or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2 in by the funeral director.		05.14/		_		perform 1 Yes 2	ned? death?		
/ital	siciar certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:] FD (0. ttit - 0. □ 1	26. Place of Death (Chec				
of	ng Phy ter this neral d	ite: To	27. Manner of Death 1 Matural 5 Pending	28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of injury	28c. Injury at work?	ursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
sion	rttendii death. ctor: Al y the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	be 28a Place of Injury - At h	1 Yes 2 No	28f. Location (Street and Number or Rural Route Number,				
Di Xi	tal or A rs after al Dire led in b		4 Homicide determined	eet and Number of Rural Route Number, , State)						
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 L Medical Exan	ysician: To the best of my knowniner: On the basis of examinations of examinations of the best of n	on and/or investigation, i	n my opinion, death occurred	at the time, date and	d place, and due to the cause(s) and manner stated.		
_	To the		29b. Signature and title of certifier	Proce Mi)	29	9c. License number	1 25	9d. Date signed (Month, Day, Year)		
U	N 2W		30 Name and address of person who	completed cause of death (Itel	m 23a) (Type, Print)	CA A	16 1 P	salhimore MJ21202		
	Stat	P	31. Date filed (Month, Day, Year)	EM) Suite / 32. Registrar's Signs	312 E , 3	0181. Paul	ace 12	en more right a		
	Registra		MAY 18 2011	32. Registrar's Signa	parket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 9.05PM W WHITAKER 05 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore (mmunity LIVING | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 19 9. Birthplace (State or Foreign Country) 1942 Kentucky Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1**x**□ M 2 □ 219-40-0237 Director 68 Nov. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore Catonsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 224 Garden Ridge Rd., Apt. 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. o. 1 X Yes 2 No
If Yes, Give
Year or Dates. Vietnam þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: White 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Pressman Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Creighton Whitaker Charmie Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen LaBuda (Per. Rep.) 224 Garden Ridge Rd., Apt. A., Catonsville, MD 21228 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Baltimore Crematory @ Loudon Park 1 Burial 2 Cremation 3 Removal from State 5/18/11 Baltimore, Maryland 4 🛮 Donation 5 🗆 Other (Specify) 22. Name and Address of FacilityLoudo. Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 22 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final) Pnysician/ ung Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Yes 2 No ed by the a a 🗌 Unknown 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 Wo 1 Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | 3 | (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar, lond 212/8 Lock Raven SURESH Shandel 3900 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wansle M) aM Medical **Examiner** 4a. Facility Name (if not institution) give street and number) 4c. County of Death Iti MOVE If Under 1 Year If Under 24 Hrs. **Funeral** In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Days Hours Min. Country) Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MOr 1 Yes 2 No ō 10e Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) orsi 19a. Informant's Name/Relationship (Tice, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location City or Town, State Date Burial 2 Cremation 3 Removal from State 2011 Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat f Funeral Service Licensee. Russ MD Payl 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rds, To the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has perform After this certificate Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 5 Pending Accident Suicide Investigation
6 Could not be Director: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, H0064267 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ka Date filed (Month, Day, 18 2011 Registrar

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		1- For State Certificate of Death	2. Date of D	Reg. No.	To 7: 100 11				
Physici dical Exam			Month May 14,	Day Year	3. Time of Death 0000 hrs				
		4a. Facility Name (if not institution, give street and number) Sinai Hospital Baltimore	Death	4c, County of Dear	h				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of	Birth(MM/DD/YYYY) 9. Bi	rthplace (State or				
Director		Usual Residence of Decedent	8/18		ountry) Janaica				
and show any nce.	5	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Ves 2 No				
r death with the Maryland or items 23a nr 28a-f show must be notified at once.	I Director	10e. Street and Number 10f. Zip Code 2120	7	10g. Citizen of What Cou	eg WeI				
	Funeral	11. Marital Status 1 Never Married 1 Never Married 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 5 Pecify Cuban, Mexican, Public Plants Company Cuban, Public Plants Company C		White, etc.	rican Midian, Black,				
215-0036 be filed within 72 hours after that Hygiene. rked atther than "natural?, ent, the Medical Examiner	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		Specify: 0	/Industry				
5-0036 lled within 7. Hygiene. Inther than the Medical	Completed	12 0 Carpenter		Carp	entry				
21215-00% uld be filed within Mental Hygiene marked uther the cevent, the Med	Be	17. Father's Name (First, Middle, Last) 18. Mother's N 10. A. Weetown	Rame (First, Middle	e, Maiden Surname)	h				
	인	19a. Informark's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 4250 Rays has the	r or Rural Route N	Number, City of Town, Stat	e, Zip Code)				
Tites		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location City o	r Town, State				
Baltimore permit. Pages 1: Department of H. Important: If it injury or nther t		4 Donation 5 Other Specify: Kensico Cemetery 5 21. Signature of Funeral Service Licenses 22. Name and Address of Facility	28/11	Valha	11a, NY				
		23a. Part I. Enter the dispase, or complications may caused the death. Do not enter the mode of dying, such as card	th Are	Basto.	MD 2/2/6 Approximate Interval				
Physician Medical Examiner		failure. List only one cause on each line Immediate Cause (Final disease a, Multiple Gunshot Wounds	lac or respiratory	arrest, snock, or neart	Between Onset and Death				
-Aaiiiiilei		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated							
ecuted and transit	Exar	events resulting in death) Last Due to (or as a consequence of): d.							
ž E a	edica	☐ UNPENDED ☐ AMENDED							
Box 68760, e death certificate be ex- the attending physician of for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	egnancy	23d. Date of deliver Month	ry Day Year				
Box e death o the atten ed for us	hysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
ires that the signed by	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		d tobacco use contribute to Yes 2 ✔ No 3 Pro					
of Vital Records, as Physician: The law require the true conficue has been sineral director, page 2 should be	Completed			topsy prior to	utopsy findings available completion of cause of				
tal Reco			1 ✔ Ye	rformed? death? es 2 No 1 ✔ Y	es 2 No				
Vital ysician:	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	ursing Home 5	Residence 6 Othe	er:				
ivision of Vital Records, P.O. Box 68760, or Atteoding Physician: The law requires that the death certificate be birector: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the buri	tion: T	27. Manner of Death 28a. Date of Injury (Month. Day Year) 1 Natural 5 Pending 28a. Date of Injury (Month. Day Year) 28b. Time of Injury 28c. Injury at Work? 2317 hrs 1 Yes 2 ✓ No	Subject s	be how injury occurred hot					
Division To the Hospital or Atteodia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 28e. Place of Injury - At home, farm, street, factory, office building, etc.	n (Street and Number or R n, State) erstown Road, Pikesvill						
the Hos hin 24 hc the Fun npletely 1	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occur							
To wit	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)				
		30. Name and address of person who completed cause of death (Item 23a)		May 14, 2011					
$0\dot{\rho}$.		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	, MD 21223						
Si Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month						Day Year		3. Time of Death	
	Medic Examin	May 6, 2011									
	Examin								:. County of Death Montgomery		
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Yea			ate of Birth		9. Birth	place (State or Foreign	
	Director		213 00 1100	rs. Months Day	s Hours	Min. May	fonth, Day, Yea $718,1$	955	Cour	itry) unk	
	d 10w	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location						10d. Inside City Limits	
	a-f sh	cto		ver Spring						1 Yes 2 X No	
	or 28	Director	10e. Street and Number	10f. Zip Code			100	. Citizen of	What Cou		
	with t	eral	2601 Bel Pre Road		2090	16	1.09	US		,	
	tems er mu	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Or	igin? (Specify Ye	es or No-			can Indian,	
ð	ifter d ", or i amin	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 △ Yes, 2 ☐ No If Yes, Give	If Yes, specify Cu			etc.)		ck, White,		
9500-61212	be filed within 72 hours after death with the Maryland ental Hygiene. Kedo other than "ratural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Completed	3 Wildowed 4 Divorced Year or Dates. VIELIIIIII					Specify		white	
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Maryland	of and 2 should be file of Health and Mental I fitem 27 is marked o r other traumatic eve			Mailing Address (Stree	et and Numb	er or Rural Rout	e Number, City	or Town, S	State, Zip	Code) 1D 20901	
αĎ	and 2				y n111						
baltimore,	permit. Page 1 a Department of B Important: If its any injury or of		1 Burial 2 Cremation 3 Removal from State cemetery,	Disposition (Name of crematory or other p	lace)	Date	200	. Location	- City or To	own, State	
	artme artme ortani injury		4 ☐ Donation 5 🗓 Other Specify) in State	State an Artei		20001 65	5 LT R	altim	ore	Street	
g	permi Depar Impo any ir once.	0 1	21. Signal re of Funeral Sar te Licens, and , mrector	Baltimore		21201	ם אי כו	altim	OLC .	Jerese	
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	nysician/	or a	shock, or Neart failure. List only one cause on each line. Immediate Cause (Noal) disease or condition Arrhythm (a)								
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200	certif ending use a	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1	2	anav.			23d. Da	te of deliv	very	
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g	require been si should I	etec									
Vital Records,		Completed					24a. Was an autopsy performed			ppsy findings available ompletion of cause of	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in the control of the c	investigation, in my opi	inion, death o	ccurred at the tin	ne, date and pl	ace, and du	e to the ca	ause(s) and manner stated.	
	To the within To the compl.	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	uge, death occurred at 29c. Licer	ine time, dat nse number	e and place, and		se(s) and ma Date signe			
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			30. Napre and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)							
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	Stat		30. Naple and address of person who completed cause of death (Item 23a) (Ty M. C. A. C. Cerr W. J. 1870 Pr. 31. Date filed (Month, Day, Year) NAY 18 2011 32. legistrar's Signature NAY 18 2011	harles				-			
	Registra	al .	MAI TO COIL COMO 12.	7	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wa Medical Facility Name (if not institution, give street and number) is TUVE COSE Sandfow 4b. City. Town, or Location of Death **Examiner** 4c. County of Death imore If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) unk 8. Date of Birth **Funeral** 1 🕅 M 2 □ F Months Days Hours Min Sept 11, 1943 Director 219-40-3583 67 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1930 W. Pratt Street #E filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, unk Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 unk If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: 3 Divorced 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Future Care Sandtown 1000 N. Gilmor Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛣 Other (Specify) in State ^{22. Name and Address of Facility} Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final hrome bstuetivo Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 2 No 1 🗌 Yes Yes director, 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner Certificate: eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred atural 5 Pending 1 Tes 2 🗌 No Accident
Suicide completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) elau

State Registrar CI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENOT

UB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3-5-PM WART 011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City_Town, or Location of Death Examiner 4c. County of Death 05 BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -0417 1 🛛 M 2 🗆 F Days Hours Country 60 Yrs **Director** ТX Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Anne Arundel Brooklyn Park must be notified 28a-f 1 Yes 2 No ō 10f. Zip Code 10g. Citizen of What Country? 5210 4th Street 21225 **23**a and 2 should be filed within 72 hours after death with 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces o. Black, White, etc. <u>8</u> 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Building Maintenance Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Constance Mae n and Mental F is marked o Unk. 2 Edward I. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5210 4th Street, Brooklyn Park MD 21225 Mary E. Gross / Friend of Health of Department of Health Important; If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State Holy Cross Cemetery 5/10/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) permit. re of Funeral Service Licensee Victor Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, 501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician | TION disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Secondary at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by norrha 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this completed filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident s after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral I 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 STEPH

Registrar

State

31. Date filed (Month, Day, Year)

8 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Early Mae Young Mav 13 2011 2:38 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Medical Center 10w5011

Real In urs last birthday) If Under 1 Year | If Under 24 Hrs. Baltimore Greater Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2□F Director 249-54-8687 32 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exminer must be notified at 1 ☐ Yes 2 X No Directo Baltimore Cockeysville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10 Silverleaf Ct. Unit D

12. Was Decedent Ever in U.S. Armed Forces?

2 INO Funeral U.S.A.

14. Race - American Indian. 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: land 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Completed by Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bonnie View be filed within Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4or 5+) 10thqrade Waitress Country Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta B.F. Gamble Sylvester Hallums 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Unit D, Cockeysville, 10 Silverleaf Ct. Kareema Pinder-Daughter Department of Healt Important: If item 2' any Injury or other once. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 5/23/2011 Owings Mills, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 3a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death In more rate Cause (Final disease or condition resulting in death) liter) left Fleural **Physician** arge /Medical Due to (or as a consequence f): Examiner thoracic aortic aneurysm descending eaking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 No 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERIONEPHOSCIEROSIS (dialysis dependent) with uremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CARdiomegaly with arterioscleratic coronary artery disease 24b, Were autopsy findings available prior to completion of cause of autopsy performed? death? Diabetes mellitus 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one this c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0028885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street Baltimore MD 21204 , MD HOWARD 32. Registrar's Signature 31. Date filed (Month, Day, Year). State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fh, g915 5-25-11 sm
State of Maryland / Department of Health and Mental Hygiene amend item 17, per fh, g915 5-25-11 sm
Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Month 925 M Stephen L. Zoepfl 14 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 490 N. Patuxent Road, Anne Arundel Lot Odenton 5. Social Security Number 6. Sex . Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Days Hours Min 59 Director 218-72-5489 Maryland Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗙 No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 490 N. 21113 Patuxent Road, Lot, USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales Rep. Sales Be 7. Father's Name (First, Middle, Last)
Felix Hugo Zoepfl
Feliz H. Zoepfl 18. Mother's Name (First, Middle, Malden Surname) မ Stelma L. Higgs 19a. Informant's Name/Relationship (Type, Print) Lva Zoepfi / Wife Lva Zoepfi / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 490 N. Patuxent Road, Lot 49, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Loudon Park Cemetery 5/20/2011 |Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause opeach line. Immediate Cause (Final teriosclerotic 158A50 Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (pras a consectionne of) If any, loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as guipt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ned for Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 XYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 \square Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier eputy 29b. Signature and title of certifier 29c. License number 10 W eted cause of death (Item 23a) (Type, Print) plame and address of person who comp mD 31. Date filed (Month. Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1050V 10:30p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 27216 Baileys Neck Road Talbot Easton 5. Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗆 M 2 😾 Months Days Hours March Day 197-16-4830 ,1923 Director 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "naturalr, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he nematical and injury or other traumatic event, the Medical Examiner must he nematical event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Talbot. Easton 1 Yes 2 X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 27216 Baileys Neck Road 21601 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Freed Ada Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail S. Aveson daughter P. O. Box 554, Easton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/5/11 Easton, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months
1 Yes 2 No Month Pregnant at time of death completed filled in by the funeral director, page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performe within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 21 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 A N မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ss of person who co ed cause of death (Item 23a). (Type, Print) mo 05 31. Date filed (Month, Day, Year . Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Kenneth Alderson 2011 3:14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 212-34-6199 74 6/25/1936 S C **Director** Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location **Funeral Director** 10d. Inside City Limits Carroll Westminster 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 2650 Cape Horn Road USA 21157 12. Was Decedent Ever in US55 Armed Forces? 1X Vas 2 No 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Divorced 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Westvaco corrugated box factory worker Be 17. Father's Name (First, Middle, Last)
John B. Alderson 18. Mother's Name (First, Middle, Maiden Surname)
Sarah K. McGinnis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Alderson, wife 2650 Cape Horn Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4/30/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License M00741 22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc **Examiner** Z-3 week Sequentially list conditions. Examine if any, leading to immediate cause. Enter or conying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death e Funeral Director. A eleted filled in by the fi 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 1 🗌 Yes 2 🗌 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗹 Certifying Physiolan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and WJL 30. Name and address of pers w complete cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hymen ALPERT April 30, Day 2011 Year 9:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number . Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** NoV. 14, Ye 1923 Hours Min Months Washington, DC Director 87 <u>579-20-6266</u> Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 28a-f shov Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Chartwell Drive 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 XMarried Completed by Specify: white 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced WW II Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Investor Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gussie Alpert Louis Alpert 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 309 Chartwell Drive, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Lee G. Alpert, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 X Removal from State 20c. Location - City or Town, State King David Memorial Garden 05/03/11 Falls Church, VA Donation 5 Other (Specify) Signature of Fun all Service Linensee Torchinskysshebrew Funeral Home MUL 008 20012 <u> 254 Carroll St., NW. Washington, DC</u> Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examiner 3 Weeks <u>Ischemia Right Lower Extremity</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last 6 Years <u>Generalized Arteriosclerosis</u> Due to (or as a consequence of) Physician/Medical that the death certificate be IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Po Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 X N or Attending Physician: The 1 Tes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 🗘 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 28780 Trout III, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814 Hugh H. 31. Date filed (Month, Day, Year) **MAY 03 2011** Registrar's Signature State Registrar

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elmo C. Alderton 28, 9:32 pm April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Country) Maryland 1 X M 2 🗆 F Hours Jonth, Day, Year) 10/05/1930 80 **Director** 213-24-6189 Usual Residence of Decedent 28a-f show the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Silver Spring 1 Yes 2 X No Maryland Montgomery 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a u.s.A. 20904 13605 Fairridge Drive items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify Specify: Caucasian 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Banking 12 Property Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Luella Shryock William Columbus Alderton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13605 Fairridge Drive, Silver Spring, Maryland 20904 Loma Alderton - Spouse or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ott 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/06/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death nock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Septic Shock Medical resulting in death) Due to (or as a consequence of **Examiner** Pneumoperitoneum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a nunscignishor) of: Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death for in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Cancer 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify hours after death.

Ineral Director: After this
d filled in by the funeral di After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the vithin 2

To the I

comple only one) 29b. Signature and titl 29c. License number

Registrar

State

Maria Tayag,

MAY 03 2011

death (Item 23a) (Type, Print)

1500

D63579

Forest Glen Road, Silver Spring, Maryland 20910

April 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician JEANNETTE CAROLYN BEARD APRIL 30 2011 11:00P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK 6895 ARBOR COURT | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 0 2 / 0 6 / 1 9 3 3 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 🗹 F 578-44-5433 78 WASH. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If Medical Extraction is trained at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No FREDERICK FREDERICK Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6895 ARBOR COURT 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ♥No If Yes, Give Year or Dates Specify: WHITE ģ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HAZEL IRENE WILLIS EDWARD MORSE FURR ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20120 19a. Informant's Name/Relationship (Type. Print) CT., CENTREVILLE, VA 14329 LITTLE ROCKY MNT. RICHARD ROONEY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 5/05/201 CEDAR HILL CEMETERY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June at Eerric License 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** seconds /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 □Yes 2 No 2 1 NO within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Regist<u>rar</u> MI

31. Date filed (Month, Day, Year)

Drive, Frederick, MD

21702

MD

/ homas

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Day 2011 William C. Birely 26, 8:40 am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛂 M 2 🗆 F Months Days Hours Min 91 Now 13, Yel 919 577-12-1512 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2XXNo Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21043 8260 Stone Crop Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
Yes 2 \(\square\) No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates. unknown 1 Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 3 Investments Investment Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Victor M. Birely Dorothy Grace Rouzer traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087819a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1069 Hillside Lake Terrace, Gaithersburg, Maryland Carolyn Birely - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4-29-2011 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 21707 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ menson months disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Dusito for as a consequence of if any, leading to immediate cause. Enter Underlying -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician Physician/Medical the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 2 🗌 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: MOSPLY 2 No 1 Yes ပ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8303

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

NO 6701

Revistrar's Signature

Charles

50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2105 April Keith Myers Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) Ct. 30,1924 1X M 2 - F 86 Director 219-14-9405 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Taneytown Carroll 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 429 East Baltimore St USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1X Yes 2 No 1943

If Yes, Give 1046 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed -1946Year or Dates. the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired)

Home Builder & Cabinet Shop Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thurman N. Brown Emma C. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 429 E. Baltimore St., Taneytown, MD Jean Brown, wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Grace Reformed Cem. 5/5/2011 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on ach line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due o (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 - No 1 Yes after death.

Director: After this certification by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) WPMEV Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only on 29b. Signatur 29d. Date signed (Month, Day, WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster istrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 28 Day 2011 Pear 12;25 pM Franklin Leon Burgess, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 XM 2 - F Months Hours Min. Mar 26, 1962 Country) Director 217-90-2121 49 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f should or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Owings Mills 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 12430 Greenspring Ave. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Lock Company 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patricia Ann Renner Franklin Leon Burgess, Sr. 19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12430 Greenspring Ave. Owings Mills, MD Franklin L. Burgess, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) Evergreen Mem Gardens 5/3/2011 Finksburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facil Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ stage disease or condition resulting in death) **End** Months Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 A No After this certificate 2 🗌 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 XNo Other: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 5 Pending 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) H004398 WJL 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover Pk Manchester MD 4175A Michael

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #19A, 5/6/11, per F. Home, E. Certificate of Death WCHD Reg. No. 2. Date of Death 3. Time of Death Physician/ April 2 Bay 20 1ª1 David Craig Bartlett 3:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 Hours OCT. Day Year) Country) 59 1951 **Director** 003-42-0187 NH Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Whaleyville Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 11501 Sheppards Crossing Rd. 21872 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Building Ind. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Bartlett Ruth Bloise 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Bartlett/wife Rd. Sheppards Crossing 11501 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State First State Crem. 5-3-2011 Millsboro, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Lan Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? igned by the atte be detached for Day Year Pregnant at time of death 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ardiac > 24b. Were autopsy findings available 24a, Was an After this certificate has autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🛂 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No I Director: A Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 5 10445 32. Registrar's Signature State Registrar

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ichael Booth		State of Maryland / 1- For State Registrar		ment of H icate of D		nd Men		Reg. N	ZUII	
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Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last I	birthday) If	Under 1 Ye	ar If Unde	r 24Hrs. 8. Date o	f Birth(MI	M/DD/YYYY) 9. Bir	thplace (State or
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Should Med is ma	2	19a. Informant's Name/Relationship (Type, Print)					ber or Rural Route			, Zip Code)
MD and 2 sho salth and em 27 is		Kathleen M. Boothe, spouse 20a Method of Disposition	20h Plac	3461 Cl			Road, Owi		MD 207. Location - City or	
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ti Pag trent		4 Donation 5 Other Specify:	Metro				05-09-11		lexandria	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		21. Signature of Funeral Service Licensee			and Addres		Radbell		ral Home	
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/Medical		failure. List only one cause on each line. Neck	injurie	es compl	licati	ng hy	pertensiv	e		Between Onset and Death
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To with	Mec	29b. Signature and title of certifier	1		29c, Licens	se number		29d.	Date signed (Mor	oth, Day, Year)
		(a. (1111 11)	/	7	O.C.	M.E.		Ма	y 9, 2011	
-	ŀ	30. Name and address of person who completed cause of de	ath (Item 23a))						
	_	Zabiullah Ali, M.D. Assistant Medical Exa		000 W. Baltir	more Stre	et, Baltin	nore, MD 2122	3		
Ct	ato	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registra MEND#23eperMD, 5/10/11; brw, McCo Certificate of Death 2. Date of Death 3. Time of Death Physician/ 0940 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mont gomen 2+ hesdA Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 F Director 0205 Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WAShingt 1 Pres 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20012 S 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zenobla OHNSON 19a, Informant's Name/Relationship (Type, Print) 🗫 . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V-daugh ST. N.W. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04-30-11 modera mi HARmeny 4 ☐ Donation 5 ☐ Other (Specify) Der artir Importa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The World & Williams William MO (182 57. W. W. UPShu Wach Dic. 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Atherosclen Physician/ Cardiorascular Medical ≟xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 □ No 3 □ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tyes 25. Was case referred to examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\supers\) Nursing Home 5 \(\supers\) Residence 6 \(\supers\) Other (Specify) Hospital: 2 No 1 Yes မ 1 Inpatient 2 PER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Direc Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death on 29b. Signature and title of certifier wow de 30. Name and address of person who compared cause of death (Item 23a) (Type, Print) MD: 15216 DINO DRIVE, BURTUNSVILLE, MD20866 CHOWDITURY, NURUL

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2, 2011 Eric Bevan Burlas 12:37 аМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1712 Pretty Penny Court Brookeville Montgomery 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Birtipin Country MD 1 X M 2 | F Months Days Hours Feb. 6, 1988 Director 220-19-2431 23 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Montgomery Brookeville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1712 Pretty Penny Court 20833 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? ģ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:White 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Demit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea once. Elementary/Seconday (0-12) College (1-4 or 5+) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) ပ္ Michael Edward Burlas Bernadette Bevan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Michael Burlas/Father 1712 Pretty Penny Court, Brookeville, MD 20833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery May 6 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD f Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Slver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not e, ter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Inset and Death Ph. sician disease or condition resulting in death) Medical s a con sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death in the past 12 months? Month 5 Other (specify) Dav Year cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No within 24 hours after death.

Jo the Funeral Director. After this certificate benefit filled in hv the fineral action of the second account of the second of the 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occ 5 Pending 1 Natural injury 5-15-178/10 1 ☐ Yes 2 🛣 No Accident Investigation 6 Could not be may 2 2011 0037 M 3 Suicide 4 Homicide 28e. Pace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ricity or Town, State) CHT) 20833 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Check 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certif 29d. Date signed (Month. Dav. Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Teresa M Brown 30,2011 8:53a. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6356 Maxwell Drive #3 Suitland Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 13,1969 9. Birthplace (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 F Yrs 226-27-6630 Director 41 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shor idical Examiner must be notifled at 1 ☐ Yes 2X No Director MD Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 6356 Maxwell Dr.#3 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager D.C.Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Eugene L Brown Vivian McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Brown (Mother) 6356 Maxwell Dr. #3, Suitland, MD. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5-7-2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis Funeral Home 101 311 N Patrick St., Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to for as a nonsequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2KNo Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours aft To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05-03-2011 Suite 200 dru CKNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 BASIL COURT LARGO, MD 20774 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 26 2011 10:38 P^{M} Elizabeth Sarah Cooper Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🖾 F Days Months (Month, Day, Year) 1935 South Carolina Director 213-90-1406 75 June Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19538 Crystal Rock Drive, Apt. 12 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 lath and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Custodian Building Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bellis Capps Lelia Petit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rose Benear / Daughter 3 Summer Sweet Court Germantown, Maryland 20876 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) May 4 ☐ Donation 5 ☐ Other (Specify) 2011 Olivet Cemetery Mt. Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 5en 515 disease or condition resulting in death) Medical Due to or as a consequence of): Examiner 4 days neumonia Sequentially list conditions, Examiner ue to (or as a consequence of): if any, leading to immediate disease the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury eripheral arterial that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic vein throm bosis hepatitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work?
1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation the 6 Could not be 3 Suicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year) 0069336 April 27 nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Nam Medical Center Drive, Rockville, Maryland 20850 Janelle Williams, MD 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park

DHMH 17 Rev 7/2009

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHANG Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☎ M 2 🗆 Months June 7, 1960 Director 50 538-90-2940 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Directo Frederick Maryland Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6917 Taran Court 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or b þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", Completed 3 Divorced Year or Dates nit. Page 1 and 2 should be filed within 72 hour artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bechtel Powr. Corp. Contracts Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Yu Ting Chang Yai Jen Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6917 Taran Court, Frederick, Maryland 21703 Rwei-Jen Lin / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.5/14/2011 Frederick, Maryland. 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Funeral Se Tart 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one had so on each line. Immediate Cause (Final Lymphoma (multi-organ involvement Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician and for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an has performed' this certificate Yes 2 N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 🖀 No ဂ 1 Plnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death.
To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ■ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated abataka MD AU4176435T19700 Tabatabai 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Si Greene St., Baltimore MD 21201 Tabatabai, MP,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

Black, White, etc.

Asian

8:51 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

mentho

1 Yes 2 No

Country)
Taiwan

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4 PRIL 1655 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MZMORIAL HOSP ITA EASTON TALBOT 5. Social Security Numbro 985 6. Sex 7. Age (1p-y rs. Jast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director bot 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Nas Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Informant's Name/Relationship (Type, Print) City or Town. 19b. Mailing Address (Street and Number or Rural Route Number, Health a permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 4 Donation 5 🗆 Other (Specify) Auneral Service Licensee any in Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxi shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC disease or condition resulting in death) OBSTRUCTIVE PULMONARY Jears Medical Due to (or as a consequence of) Examiner TOBACCO year S Securettally fist our fittens Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed ARTERY DISTASE 24b. Were autopsy findings available prior to completion of cause of death? CORDNARY funeral director, page 2 autopsy performe After this certificate Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after death
 Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Ewithin 2 To the F only one) 29b. Signature and title 64043 April 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID 21601 W. MOUTE, 5 WISHINLTON ST CASTON 31. Date filed (Month, Day, Year) . Registrar's Signature State MAY 05 201 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Month <u>Yelizaveta Chernova</u> Medical April 8:10 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year | If Under 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 □ M 2 **X** F Days Hours 04/14/1930 Director Yrs. Country) 216-47-2693 Ukraine Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f 1 X Yes 2 □ No MD Montgomery <u>Rockvill</u>e 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Rollins Ave. 20852 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Chemical Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ilya Chernov Sofiya Chernova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Roth / Daughter 5630 Wisconsin Ave. #902 Chew Chase. MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Memorial Grnds: 04/27/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 MO1477 <u>Blake</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Congestive Heart Failure Examine Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month 1 Yes 2 No 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.

Sompleted filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 **K** DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide 1 Yes Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my kind wedge. See the continuous of the table date and place and due to the cause(s) and manner stated. (Check only one d at the time, date and place, and due to the cauce(c) and marmer as state. 29b. Signature and title of certifier cees 04-25-2011 5632 Amapelis Ru. #3 Bladenburg, Md 20110 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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VICKEN K. Poochikiun

31. Date filed (*Month, Day, Year*) **MAY 02 2011**

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49.00			Holy Cross Hospital		Silver	Spring		Montgom	
	Funeral Director		220-65-9612 1 □ M 2 X F	(In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bi (5, Yea <i>r</i>) 1971 Ha	rthplace (State or Foreign ountry)
	and show	ē	Usual Residence of Decedent 10a. State 10b. County -	10c. City, Town or Loc	ation				10d. Inside City Limits
	Maryl 28a-f ootifie	Funeral Director		Kensington					1 🗆 Yes 2 🗶 No
	vith the 23a or st be n	ralD	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	*
	eath v tems er mu	Fune	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. W	20895 /as Decedent of H			United St	
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 XX No. If Yes, Give Year or Dates.	1	Yes, specify Cuba	Specify:	o Rican, etc.)	Black, Whi	te, etc.
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Mar	C 4 7 7		19a. Informant's Name/Relationship (Type, Print)	1				City or Town, State, Z	
ē,	other		Diane Laviolette, Friend 20a. Method of Disposition	20b. Place of Dispos	ition (Name of		Kensing	20c. Location - City or	
imo	Page ment o tant; If tury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crema	atory or other plac	^{e)} May		Silver Spr	
Ball	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		21. Signature of Funeral Service Licensee M01102	1.0	Name and Addres		_	bute ille, Mary	1and 20852
	Ph. i i Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a c	ary Emboll onsequence of):		g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death Odays
3760	ficate be executed g physician and as the burial-transit	Aedical Examine	cause. Enter Underlying Cause (unsease or inipury that initiated events resulting in death) Last c. Due to (or as a c	onsequence of):					
9 XO	death certificate attending ped for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date of de Month	livery Day Year
Э.	the by tl ach	<u> </u>	Part II. Other significant conditions contributing to death but	not resulting in the und	derlying cause giv	en in Part I.	23a Did tob	pacco use contribute to	the cause of death?
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Records, P.O. B	The law requires that the de cate has been signed by the page 2 should be detached	Completed by						n 24b. Were au prior to death?	
ital Records, P.O. B	sician; The law requires that the certificate has been signed by the rector, page 2 should be detach	Be Completed by	25. Was case referred to medical examiner? 1 X Vs. 2 \[\] No Hospital:		Otho	ice of Death <i>(Chec</i>	1 Yes 2	24b. Were au prior to death?	robably 4 Unknown topsy findings available completion of cause of 2 UNo
of Vital Records, P.O. B	ig Physician; The law requires that the ter this certificate has been signed by the reral director, page 2 should be detach	To Be Completed by	examiner? 1 X Yes 2 \(\text{No} \) Hospital: 1 \(\text{Inpatient} \) 27. Manner of Death 28a. Date of injury	2 X ER/Outpatient 28b. Time of	3 DOA Othe	ice of Death (Chec r: 4 Nursing H	1 Yu 24a. Was au autops perforr 1 Yes 2 k only one) The second of th	n 24b. Were au prior to death?	robably 4 Unknown topsy findings available completion of cause of 2 UNo
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Division of Vital Records, P.O. Box 68	or Attending Physician; The law fer death. ricetor: Affer this certificate has n by the funeral director, page 2	Certificate: To Be Completed by	examiner? 1	ear) 28b. Time of injury - At home, farm, stree Specify)	3 DOA Othe 28c. Injury work; 1 St. factory, office	ce of Death (Chece r: 4 Nursing Hoat at at yes 2 No	24a. Was ar autops perform 1 Yes 2 k only one) ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	24b. Were au prior to death? 2 k No 1 Yes	trobably 4 Unknown Intropose the first state of the stat
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month 5 Cropper 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death 1(om)c If Under 24 Hrs. 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, March) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 KF 220-68-8106 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Anne Princess Somerset 1 🎢 Yes 2 🗌 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SL#E U.S.A. 11635 Beech wood 21853 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗡 No Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bel-Art Plastic Co. Laberer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Post office Rd Princess Anne me mother 30693 Bivens -Anna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Princess Anne, md, John Wesley Cameter 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anthony E. Ward 30639 Ave Hampden Anne, md, 2857 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACOUIRED DRFFIGENCY SYNDROWA IMMUNIZ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No Completed 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has I autopsy performed Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury injury Natural 5 Pending Accident A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signati 0 12005 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAM 2/802 32. Registrar's Signature

State

Registrar

0 5 201

11-03410 Kenneth Lee Jor	rdan	Please Type or Print in Black Indelible Ink. Ensure All Copie Danner, Jr State of Maryland / Department of Health and Mental H		egible.	
\		11- For State Crivial yiand / Department of Freath and Wentai Free Certificate of Death Registrar		Reg. No. 201	1595
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Kenneth Lee Danner, Jr.	2. Date of De Month May 6, 20	Day Year	3. Time of Death 0248 hrs
()		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick	n	4c. County of De Frederick	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	⊣	irth(MM/DD/YYYY) 9.	
Director		231-59-2397 1 2 F 20 Yrs. Months Days Hours Min		17 , 1990	reign Country) Virgini
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. C			10d. Inside City Limits
yland n-f shov	ģ	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	1 X Yes 2 No
vith the Maryland 23a or 28a-f show a 2 notified at once.	I Director	707 E Potomac St. #3 21716		U.S.A.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Headth and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 14. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 15. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 16. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 17. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 18. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 19		o- 14. Race - An White, etc	nerican Indian, Black, c.
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1215 d be fill fental H arked	Be	Kenneth L. Danner Sr. Nichole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			7 2 4
MD 2 d 2 shoul lth and M n 27 is m	٩	19a. Informant's Name/Relationship (Type, Print) Kenneth L. Danner Sr. Father 707 E Potomac S			
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Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other Specify:			
Bal perm Depa Impo		21 Sunature of Funeral Service Licensee Lot 1158 Catoctin Cr.	udoun . SE L	Funeral (eesburg '	Chapels VA 20175
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List or ty one cause on each line.	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
Ėxaminer		Immediate Cause (Final disease or condition resulting in death) a. Oxymorphone and Alcohol Intoxication Due to (or as a consequence of):			Deau
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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ecuted and transit	-	d.			
50, e be ex ysician burial	edic	IF FEMALE: 23c. If yes, outcome of pregnancy	l sm	22d Date of deli-	
Box 68760, e death certificate be ex the attending physician ed for use as the burial.		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ancy	23d. Date of delive	Day Year
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and oppose in by the funeral director, page 2 should be detached for use as the burial - trans	ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death? robably 4 Unknown
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Sior Attend r death. rector: by the	icatic	2 X Accident Investigation fd 5-6-11 fd 1:50 am 1 1 1 1 1 1 1 1 1		t ingested Street and Number or	Rural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Directors tely filled in by the	Certification:	4 Homicide determined (Specify) Friend's Residence	or Town, S Knoxvi	State) 3510 01: 11e,Md.	ive School Rd.
To the Hos within 24 h	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cau at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
S with	Me	and manner stated. 29c. License number		29d Date signed ()	Month, Day, Year)
		O.C.M.E. 30. Name end address of person who completed cause of death (Item 23a)		May 7, 2011	
2		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltim	ore, MD 21	223	
St Regist		31. Date filed (Month, Day, Year) MAY 1 1 2011 32. Rigistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Stanley Dickter April 29, 2:40p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 X M 2 🗆 F Hours 07/11/18 068-10-0580 Director 92 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. 1X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Adclare Rd. 20850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married and 2 should be filed within 72 hours after of Health and Mental Hygiene. Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Publications Manager US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Dickter Ruth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence Dickter/Son 410 Lanark Way Silver Spring, Md. 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Judean Memorial Gardens 5/1/11 22. Name and Address of Facility
Danzansky Goldberg Memorial
II/O Rockville Pike Rockvil 21. Signature of Funeral Service Licensee M00910 Chapels Edward Sagel 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Other (specify) Month Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cerebrovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Tes Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work within 24 hours after death to the Funeral Director: A completed filled in by the fo 1 Tes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064624 04/30/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 743 Summer Walk Drive Sandeep Sharma Gaithersburg, Md. 20878 31. Date filed (Month, Day, Year, State

Registrar

11-03436 Justin Kirk Walk	er E	mswiler State 1-For State Amended #10	or Print in Bla e of Maryland / f & 19b per	ack Ind	elible Ir	nk. Ensu Health a Death	r e All (nd Mer	Copies Are ntal Hygiene		20	Production ()	15953
Physici	an/	Decedent's Name (First, Middle,La	ast)		nouto or	204.7		2. Date o Month		Year		Time of Death
Medical Exami	ner	Justin Kirk Wal		er		I Oit T		May 7	, 2011	. County o		0915 hrs
		 Facility Name (if not institution, g 1736 Springfield Lane 	give street and number)		1	b. City, Town, Frederick	or Location	or Death		rederick		
Funeral Director			Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Y Months D	ear If Und	e Min	of Birth (MM/	i i	Foreign	ace (State or y) Marylane
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aryland	Director	10e. Street and Number			it Ally	10f. Zip Code			10g. Citi	zen of Wha	at Country	?
the Man or 2		602 Prospect	Road			-2	1793	21771	US	A		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic eveot, the Medical Examiner must be positified at 90cc.	by Funeral	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2X	Ever in U.S.	If Y€	es, specify Cub	an, Mexicar	gin? (Specify Yes n, Puerto Rican, etc		White,		Indian, Black,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Las Kirk Emswile	•					r's Name (First, Mic nberly Kn		Surname)		
MD 212 d 2 should be tth and Ments n 27 is mark	To B	19a. Informant's Name/Relationship Kirk Emswiler -			19b. Mailing 602 P	Address (Str	eet and Nur	-	Number, C	ty or Town	n, State, Zi _l	^{Code)} 21771
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/Medical Examiner	1	failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	each line. a. Oxycodone Due to (or as a consec		icatio	n and a	1coho	1 use				Between Onset and Death
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3760 ficate l g phys s the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnar		al death	Ectopi	c pregnancy	230	i. Date of o	delivery Day	Year
Box 68 death certi he attendin d for use a	Physician/Medical	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at t	ime of death	=	er (Specify)		o programoy		Worker -	Duy	104
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Floweral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Š	Part ii. Other significant conditions	contributing to death	but not resu	ılting in the ur	nderlying cause	e given in Pa	art I. 23e. I			_	cause of death? y 4 Unknown
ords w requ	Completed								Was an autopsy	pr	nor to comp	sy findings available pletion of cause of
Rec The la	mo.								performed? res 2 N		eath? ✔ Yes	2 No
ician: s certifi	Be	25. Was case referred to medical examiner?	Hospital:	· o re	3/0-111		045	(Check only one)			0	
of Vigeral di	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	y 28	R/Outpatient Bb. Time of in		jury at Work	Nursing Home !	ribe how inju			ene
OD C ceedion sath. or: Af	tion	1 Natural 5 Pending			d 9:00	am ¹□	Yes 2 🗶	No Unkno)WII)			
Divisi nital or Att urs after d urs after d urs after d urs after d	Certification:	2 Accident Investiga 3 Suicide 6 K Could no determin	ot be 28e. Place of Inju					tc. 28f. Locat	ion (Street a	nd Number 736 S	r or Rural i	Route Number, City gfield Ln.
Divisior To the Hospital or Atteod within 24 hours after death To the Foueral Director: completely filled in by the	Medical C	Chican only	ician: To the best of my er:On the basis of exam and manner stated.	_								ause(s)
	Ă	29b. Signature and title of certifier	N.				nse number	OCME			d (Month,	Day, Year)
		Theodon M	Cord o	Russ	(,,	0.0	C.M.E.		May	8, 2011	I	
0		 Name and address of person who Theodore M. King, Jr., M 		•	/	900 W. Balt	imore Str	reet, Baltimore	, MD 212	23		
		24 Data Blad day in Book	011 32. Registrar	s Signature		Kel						
Regis	trar	MAI 132	VIII CONSTA	- Jo	7					_		

11-03348

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Pamela Edmone	as	1- For State Registrar	Stat	te of Maryla	•	oartment o e <i>rtificate o</i> a			Mental	Hygiene	Reg. N	20	And the second	1595
Physici Medical Exami		1. Decedent's Nam		Last)						2. Date of D	Death Da			3. Time of Death
inedical Exam		4a. Facility Name (if not institution, give street and number) 4b.							May 2, 2011 4b. City, Town, or Location of Death 4c. County of Death					
No			laryland Hos		7 4-2 //	Last triated as A	Clinton		K1110	us. In Data of	Diet ()	Prince Ge		
Funeral Director		5, Social Security N	7620 1	Sex	7. Age (In yrs	i. last birthday) Yrs	If Under Months	Days	If Under 24 Hours	N. Alica		1958	9. Birth Foreign Coui	place (State or WASHINGTO) ntry) DC
any		Usual Residence o 10a. State	10b. County		10c. Ci	ty, Town or Locat	ion							10d. Inside City Limits
. €	F	MD	PRINCE	GEORGE '	S	CHELTENH	AM							1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Nu	mber		 	· . · · · · · · · · · · · · · · · · · ·	10f. Zip C	ode			10g. C	itizen of Wha	Count	ry?
th the] 23a or gotifie		9614 SPI	NNAKER				2062					SA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante event, the Medical Examiner, must be notified at once.	y Funeral	11. Marital Status 1 Never Marri 3 Widowed	-A		2 v No			Cuban, N	Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - White,		an Indian, Black,
ours a	ed by	15. Decedent's Ed				16a. Deceden			n (Give kind O NOT use		16b	. Kind of Busin	ness/In	dustry
136 hin 72 hours after e. than "natural", edical Examiner.	plet	Elementary/Second	ondary (0-12)	College (1	-4 or 5+)					,		DDTU	ידייוו	
d with ygiene other t	Completed	17. Father's Name	(First, Middle, La	ast)		REC	ORDS 1			ame (First, Middle	e, Maide	PRIVA en Surname)	ATE	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica	Be	NATHAN									OHN			
MD 2. d 2 should th and M n 27 is m umatic c	٩	19a. Informant's Na ROBERT E			A NID	1.0		•		or Rural Route N ロロアークロロエ		•		Zip Code) AND 20623
e, M I and 2 Health item 2		20a. Method of Disp	position		20b	. Place of Dispos	ition (Name			Date		c. Location - C		
Baltimore, permit. Pages I ar Department of Hee Important: If ite			Cremation Other Spec	3 Removal fro	om State	crematory or oth RIVERDAL		ATO	RY 5	/12/2011		RIVERDA	ALE.	MARYLAND
altii.		21. Signature of Fu				22. N	ame and Ad	dress of	f Facility	J. B. JE	NKI	NS FUNE	ERAL	HOME, INC.
		23a. Part I. Enter th		allow	aused the deal									AND 20785 Approximate Interval
Physician /Medical xaminer			ly one cause on Final disease		myocaro	dial inf			as calula	ac or respiratory	an 651, 5	TIOCK, OF TICALL		Between Onset and Death
		Sequentially list cor		b.	consequence	or).								
	iner	if any, leading to imcause. Enter Under	nmediate erlying Cause	Due to (or as a	consequence	of):							- 1	
cuted nd iransit	I Examiner	(Disease or injury if events resulting in i	death) Last	Due to (or as a		,								
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687 certifica nding p		IF FEMALE: 23b. Was decedent past 12 months 1 Yes 2 1	?	1 Live bi	ant at time of c	2 Fet	al death ner (Specify,		Ectopic pre	gnancy	2	3d. Date of de Month	livery Da	y Year
P.O. es that the gened by be detach		Part II. Other signif		s contributing to	death but not	resulting in the u	nderlying ca	use give	en in Part I.					e cause of death?
of Vital Records, P.O. Box og Physician: The law requires that the death ther this certificate has been signed by the atteneral director, page 2 should be detached for uneral director, page 2 should be detached for the present of the page 2 should be detached for the page 3 should be 4 shoul	ompleted									per	as an lopsy formed?	prio dea	r to cor	psy findings available inpletion of cause of
ian: 1	BB	25. Was case referr examiner?	ed to medical	Hospital:					Death (Che					
of Vii	٩		2 No	Hospital: 1 / Ir	npatient 2	ER/Outpatient 28b. Time of Ir			her Nu	rsing Home 5		dence 6 (Other:	
C # . ~ 2	cation	1 X Natural 2 Accident	5 Pending	ation (Month,	Day,Year)	nome, farm, stree	1	Yes	2 No				r Rura	Route Number, City
E 0 0 0	Certifi	3 Suicide 4 Homicide 29a. Certifier	6 Could no determin	of be ned (Specify)						or Town	, State)			Trodo (Valles), Oly
To the Howithin 24 h	Medical	(Check only	Medical Examin	ician: To the best er:On the basis o and manner st	f examination	and/or investigati	on, in my op	inion, de	and place, a eath occurre	and due to the ca	te and p	lace, and due	to the	cause(s)
	Ž	29b. Signature and	title of certifier	Valler	T/el	200	TW.	cense n			1 .	Date signed by 5, 2011	(Month	n, Day,Year)
CR		Name and addressVictor Weed		o completed cause Assistant Med			Baltimor	re Stre	eet, Baltin	nore, MD 21	223			
Sta	ate	31. Date filed (Monti	h, Day Year)	32. Reg	gistre's Sign	all								

OCME

11-03496 Stephen Fuller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stephen Fuller	1- For State Registrar	f Maryland / Departi Certif	ment of Health ar icate of Death	nd Mental Hyg	iene Reg. N	201	1 1595
/Physician Medical Examine	Decedent's Name (First, Middle,Last) Charles Teal 1				Date of Death Month Day	Year	3. Time of Death 1956 hrs
O DATE OF THE PARTY OF THE PART	Stephen Fuller 4a. Facility Name (if not institution, give s	street and number)	4b. City. Town. o	r Location of Death	May 9, 2011	4c. County of Deat	
	1167 Appleton Road		Elkton			Cecil	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last I			B. Date of Birth(M	M/DD/YYYY) 9. Bir	
Director	221-54-1452 13/1	1 2 F	52 Yrs. Months Da	ys Hours Min.	01/14/19	Foreign Co	ountry) DE
any	Usual Residence of Decedent 10a. State 10b. County	10c City Toy	wn or Location				10d. Inside City Limits
B 1							1 Yes 2 X No
the Maryland a or 28a-f show	MD Cecil 10e. Street and Number	E1kt	On 10f. Zip Code		10a. C.	itizen of What Cou	
the M Lifted Dire	1167 Appleton Rd.		21921				,
11215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Specif	fy Yes or No-		ican Indian, Black,
or ite	1 Never Married 2 Married	Armed Forces? 1 Yes 2 X No	If Yes, specify Cuba	n, Mexican, Puerto Ric	an, etc.)	White, etc.	
ral",	3 Widowed 4 X Divorced If	r Dates:	1 Yes 2 X No				ite
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exam	Elementary/Secondary (0-12)	College (1-4 or 5+)	 Decedent's Usual Occupation during most of working life 	ation (Give kind of work e. DO NOT use retired)	done 16b.	Kind of Business/	Industry
036 ithin 7 ne. r than fedica	12	-2 -	Plumber/Pipef	itter		Union	
15-00% liled within Hygiene. Hygiene the Med	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fir			
ID 2121: should be fil and Mental I: 77 is marked natic event,	John W. Fuller, J 19a. Informant's Name/Relationship (Type			Barbara A			
b, MD 21215-0036 and 2 should be filed within 7 teath and Mental Hygiene. team 27 is marked other than traumatic event, the Medica To Be Comple	Stephanie Fuller/		9b. Mailing Address (Street				, Zip Code)
0. 8 2 2 E	20a. Method of Disposition	20b. Place	1167 Appleto e of Disposition (Name of ce	metery. Da	ate 20c	Location - City or	Town, State
nor	1 Burial 2 XCremation 3	Nomoval Irom State	natory or other place) Foard Funer		/2011	1-1 C	MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other transcription.	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	2. 1	22 Name and Address	s of Eacility	.A. K	ising Su	n, MD
	21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complice	tol	259 E. Ma	d Funeral I in St. Elki	Home, P. ton, MD	A. 21921	
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the death. Do line.	not enter the mode of dying,	such as cardiac or res	spiratory arrest, sh	lock, or heart	Approximate Interval Between Onset and
Examiner		pertensive car	diovascular d	lisease			Death
	Sequentially list conditions, b	e to (or as a consequence of):					
miner		e to (or as a consequence of):					
1 65	(Disease or injury that initiated C.	e to (or as a consequence of):					
and transit	d.						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex		MENDED 23a,pt.II	,27,per me,g9	15 6-1-11	SIL		
876(ificate ificate g phys s the b	23b. Was decedent pregnant in the	23c. If yes, outcome of pregnanc		Estacia ara ananan	23	d. Date of delivery	
). Box 6876 the death certificate by the attending phy ched for use as the Physician/M	past 12 months?	Pregnant at time of death	2 Fetal death 3 Other (Specify)	Ectopic pregnancy	10	Month D	ay Year
Bo te deat the att red for		9 Unknown					
i, P.O. ires that the signed by the detach		ntributing to death but not resulti	ing in the underlying cause g	given in Part I.			he cause of death?
ords, I w requires s been sig should be	Diabetes mellitus				1 Yes 2 2		opsy findings available
Records, The law requires ficate has been sig spge 2 should be					autopsy performed?		opsy findings available ompletion of cause of
tal Recidins: The lector, page	25 Mas ages sefermed to madical				1 ✓ Yes 2 N	lo 1 🗸 Ye	s 2 No
Vital ysician ysician bis cert directo	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ER/0		of Death (Check only of Other, Nursing Ho		ence 6 🗸 Other:	Canno
of Ving Physical After this funeral diagrams.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b		· rtdroing / io	. Describe how inj		
ion tendir tor: A the fu	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,Yeer)	1 1	es 2 No			
Division of ital or Attending us after death. ral Director: After led in by the fune	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office b		Location (Street a	and Number or Run	al Route Number, City
Div Ospital or hours afte meral Diu y filled in	4 Homicide determined	(Specify)					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Check only	To the best of my knowledge, de the basis of examination and/or					
To To		d manner stated.	29c. License			Date signed (Mon	
	()_7		O.C.1			/ 10, 2011	,,,
-	30. Name and address of person who com	pleted cause of death (Item 23a)					
		sistant Medical Examine	r 900 W. Baltimore	Street, Baltimore	, MD 21223		
State Registrar	31. Date filed (Month, Day Year) NAY 1 3 2011	32. Registrar's Signature	wed				

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Justin	Adam	Glusc	evich

istin Adam Glusc	1- For State Certific Registrar	ment of H		Mental Hy	Reg	201	1595
Physician/ ledical Examine					2. Date of Death Month May 9, 201	Day Year 1	3. Time of Death 1219 hrs
	4a. Facility Name (if not institution, give street and number) 1107 Key Parkway #203		City, Town, or Lo rederick	cation of Death		4c. County of Dea Frederick	th
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last I 216-15-9962 1 M 2 F 33		f Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth July 9	(MM/DD/YYYY) 9. B Fore	irthplace (State or ign Maryland ountry)
nd how any Ec.		own or Location ederick					10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once,	10e. Street and Number 1107 Key Parkway	10	of. Zip Code 217 ()2	10g	untry?	
fter death with ", or items 2: ter must be n	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, s	ecedent of Hispa specify Cuban, M	lexican, Puerto I		White, etc.	rican Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Menhal Hygiene. In If Item 21 to marked other than "natural", or items 23a or 28a-1 short or other traumatic event, the Medical Examinet must be notified at once To other traumatic event, the Medical Examinet must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's U during most o	Jsual Occupation of working life. Do			6b. Kind of Business power was company	,
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Lincoln Gluscevich	19h Mailing Ad		Jo Elle	(First, Middle, Ma	iden Surname) er, City or Town, Stat	e Zin Code)
MD 2 should and 3 m 27 is m 27 is m T	Jo Ellen Gluscevich - mother	8018 G	lendale	Drive,	Frederic	ck, Maryla	and 21702
Baltimore, permit. Pages 1 ar permit. Pages 1 ar Cappartment of Hes Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State Stau:	ce of Disposition matory or other p	place)	.	Date 3	20c. Location - City o	Town, State Maryland
Balt permit. Depart Impor	21. Signature of Funeral Service Licensee		and Address of	Sta	uffer Fu	neral Hon lerick, Ma	ne ervland 2170
Physician /Medical Examiner	23a Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	not enter the m	ode of dying, suc	h as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
	events resulting in death) Last Due to (or as a consequence of): d.						
o, o, e be execu e be execu ysician and burial - tra	x unpended ☐ AMENDED 23a,27,28		me,g91	5 6-2-1	l sm		
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transionappleted by Physician/Medical E.	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 1 Yes 2 No 9 Unknown 1 Unknown 2 Unknown	2 Fetal de	eath 3 (Specify)	Ectopic pregnan	су	Month	y Day Year
ires that the d signed by the lbe detached d by Phy	Part II. Other significant conditions contributing to death but not result	ting in the under	lying cause give	n in Part I.		cco use contribute to	the cause of death?
of Vital Records, ag Physician: The law require the this certificate has been signered director, page 2 should b. To Be Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vital F ysician: his certifi director, I	25. Was case referred to medical examiner? 1	/Outpatient 3		Death (Check or		sidence 6 🗸 Othe	ar: Scope
	27. Manner of Death 28a. Date of Injury (Month Day Year)	b. Time of Injury	28c. Injury a	t Work?	28d. Describe hov		i. Scelle
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, IAMED TO TO TO THE TO THE TO THE TO THE T	Pending Investigation Accident Pending Investigation Fd 5-9-11 Fd	1 12:19 p		ing, etc. 2			ural Route Number, City
E Hospital 124 hours Funeral etely fille	4 Homicide determined (Specify) found at 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	death occurred a		and place, and d	ue to the cause(s	and manner as sta	
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	or investigation, i	n my opinion, de 29c. License nu			d place, and due to the signed (Mo	
	0m/		O.C.M.E		1	May 10, 2011	, 23,, 700,
0	30. Name and address of person who completed cause of death (Item 23a Donna M. Vincenti, MD Assistant Medical Examine		Baltimore St	reet, Baltimo	ore, MD 2122	3	
State Registrar	31. Date filed (Month Day, Year) 2011 32. Registrar's Signature	back	1				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 26, Day 2011 Year Myra Virginia Garst 3:40 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F March 18, Maryland Months Hours Min 212-24-5664 85 Director Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖁 No Marya1nd Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7404 Willow Road 21702 United States within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced Specify: Completed Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles H. Himes Myra Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fox Rock Drive, Myersville, Maryland 21773 Myralee Wiles / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2011 4 Donation 5 Other (Specify) Resthaven Memorial Frederick, Maryland Signature of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick 23a. Part —Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Rnysician/ disease or condition resulting in death) <u>uears</u> Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to for se a nonesquence of, cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician; The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: ISe yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) Day has been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate Yes 2 No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📉 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural Accide work? 1 Yes 2 No 5 Pending injury To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To only one 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Richard L. Gough

2 201

31. Date filed (Mc

egistrar's Signatu

PO Box 328, Walkersville, MD 21793

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 0910 A M GUECTUE Physician/ 2011 DMLAN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY OLNEY GENERAL HOSPITAL MONTGOMERY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 29, 7. Age (In yrs. last birthday) Social Security Number Days Funeral Months Hours 1 🛛 M 2 🗆 F 214-59-7083 56 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 22 minute any injury or other traumatic event. the Maryland once. Director 1 Yes 2 V No Silver Spring Montgomery MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20905 Funeral 1302 Elm Grove Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No 1 Never Married 2 X Married Specify: Black ģ 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Finance Accountant 4 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ Guegue Abouya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1302 Elm Grove Circle, Silver Spring, MD 20905 Ayawovi F. Guegue / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 05/07/2011 Atlantic Crematory 4 Donation 5 Other (Specify) ²². Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee M00956 23a. Part 1 Ent The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death RESPIRATORY FAILURE Immediate Cause (Final HYPERCARBIC Physician/ disease or condition Medical resulting in death) Examiner NEUMONIA Sequentially list concilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and the cause of Examine CENTRAL The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal steries Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Veal in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown PROGRESSIVE MYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HISTORY OF CVA autopsy performed page 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manney of Death Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funer. work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide
4 Homicide

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier (Check

OLUYEM(SI 31. Date filed (Month, Day, Year)

To the Hospital

determined

rewringerius

ADEWUNMI, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D59418

MONT GOMERY

29d. Date signed (Month, Day, Year) APRIL 28, 2011

GENERAL HOSPITA

11-03208 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Pedro Balvas-Guadarrama 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1136 hrs **Medical Examiner** April 27, 2011 Balvas Guadarrama 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Bayyiew Hospital** Howard 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Funeral Foreign Country)Mexico Days Months Hours Director APR 04, 1950 622-14-9220 1XM 2 F 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Quantrail Way 21205 United States 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married Yes 4 X Divorced If Yes, Give Year 1X Yes 2 No specify: Mexican Specify: Caucasian é 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) rmit. Pages I and 2 should be filed within 72 h partment of Health and Mental Hygene. pportant: If item 27 is marked other than "n ury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) 3altimore, MD 21215-0036 Clothing Manufacture Business Owner 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Felix Balvas Romero Cira Guadarrama 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Rodman Way, Baltimore, MD 21205 Francisca Vasquez / sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Cuerna Vaca, Morelos 1 X Burial 2 Cremation 3 X Removal from State Cementario Zapata 05/04/2011 Mexico 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithershurg, MD 2 Enfer the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, S x AMENDEDitem 1 ,per me,g916 6-6-11 sm After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial -UNPENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Pending within 24 hours after death. filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar's Signature

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

April 28, 2011

Melissa Brassell, MD

31. Date filed (Month,

rasu (

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 26, Day 2011 Year Solomon Goldenberg 9 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Examiner County of Death Bedford Court Assisted Living Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DC 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 577-24-5657 87 Days Min 1**X**□ M 2 □ F Months Hours 2/18/1929 Director Usual Residence of Decedent ıtal Hygiene. əd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15100 Interlachen Drive #311 20906 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give W
Year or Dates. Black, White, etc. White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced WW II Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4^{College (1-4 or 5+)} Supply Systems Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important; if item 27 is marked other tha any injury or other traumatic and ince. Management Analyst Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 Marcus Goldenberg Rose Scheinerman 19a. Informant's Name/Relationship (Type, Print) - Daughtet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Goldenberg Phillips 9431 Vernon Drive Great Falls VA 22066 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place) David Memorial Gardens King 4 ☐ Donation 5 ☐ Other (Specify) 04/28/2011 Falls Church, VA 21. Signature of Funeral Service Lin 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 1. Enter the dis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Findisease or condition (Final Coronary Artery Disease Ph_sician/ lears Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Atrial Fibrillation autopsy performed 2 No Yes 2 👿 No 1 Tes To the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Director: After this in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending injury work?
1 Yes 2 No Certifica Accident nvestigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Funeral 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medicat within 2

To the I

comple Certifying only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 20 April 27, 2011 who completed cause of death (Item 23a) (Type, Print)
3801 International Drive #211 Silver Spring MD 20906 Name and address of person will Nakul Goyal MD

State

Registrar

31. Date filed (Month, Day, Year)

MAY 02 2011

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 28, D2/011 Glasby Marie 6:59 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 113-30-3909 1 M 2 X F 70 Sept. 22 1940 Country Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20902 USA 2643 Cory Terrace filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify:White "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elouise Caron Leland LaTulip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2643 Cory Terrace, Silver Spring, MD 20902 Tina M. Fox/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State $5/2^{\text{ate}}/11$ 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State injury or Department of Important: If any injury or Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., SIlver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Wel Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on attending physician and for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical 引なられ、しなく 4化学2011 Ov Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No is certificate has been signed by the director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

State Registrar

DHMH 17 Rev 7/2009

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29a. Certifier

29b. Signature and title of certifier

Melissa Means, MD

31. Date filed (Month, Day, Year) **MAY 0.2** 2011

- 2 means

Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8600 Old Georgetown Road, Bethesda,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tong 201 030 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 77 24 Janer 4 6. Sex Social Security Number 9. Birthplace (State or Poreign Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 🛡 F Country) Virginia 215-12-5367 96 Director March Usual Residence of Decedent 23a or 28a-f show f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17724 Parkridge Drive 20878 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 School Bus Driver County Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Boate Myers Molly Stovall Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i Norman J. Howard, Jr./ Son 74 Bond Road, Blairsville, Georgia 30512 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Neelsville Cemetery 04/30/2011 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, MD 20872 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition WEEK Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that the death certificate be executed eans resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 XNo 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a autopsy performed has 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pendina 1 Yes 2 No Je/1 after death

Director: A

d in by the f Accident Investigation pr 16 2011 000 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City, or Town, State) プス filled in by determined Horne To the Hospital of within 24 hours a To the Funeral D completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause 31. Date filed (Month, Day, Year) State 9 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 A-M Month Physician/ Vera Lee Hope Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) . Age (In vrs. last birthday **Funeral** Hours 05/11/1946 1 □ M 2 💢 F 219-44-6315 64 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1X Yes 2 ☐ No MD Carroll Westminster 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21157 USA 84 Pennsylvania Avenue Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: If Yes, Give White 3 Midowed 4 ☐ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant State of MD Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Emma Jeanette Leister Harry Joseph Brothers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heather J. Wartburg, daughter 67 Sycamore St., Westminster, MD 21157 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 04/29/2011 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 22. Name and Address of Facility Pritts Funeral Home & Chapel 21. Signature of Funeral Service Licensee and (D) 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BOWEL ISCHEMIC Sequentially list conditions, if any leading to mine data cause. Enter Underlying Due to or as a conse uence of): Examine ECAL IMPACTION Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown FAILURE 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the f 6 [Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 WJL 4-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHCO, MD ZOO MEMORIAL AVE, WESTMINSTER, MD KHOO, MD FRANCIS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year lico Howes 0940 AM Medical 22 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 👿 F Days (Month, Day, Year) 2-21-1919 Hours Min. **Director** 219-38-2701 91 Annapolis. Usual Residence of Decedent or 28a-f show 10a. State 10b. Count the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 972 Chesapeake Avenue 20751 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married within 72 hours after þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3

Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Baker Retail Bakerv injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Edward Ford Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Raley, daughter 5967 Brooks Woods Road, Lothian, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗅 Donation 5 🗆 Other (Specify) Woodfield Cemetery 05-05-2011 | Galesville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. any 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Yes 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 24 hours after death npleted filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061783 2011 30. Name and address of person who completed cause of cleath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Chang Choi

31. Date filed (Month, Day, Year)

M.D.

100

Hospital Rd.

32. Registra s Signature

Prince Frederick, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Month Year Physician/ Hajdasz 1:31 AM Frances May 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5814 33rd Avenue Hyattsville Prince George's 9. Birthplace (State or Foreign Country)
Onancock, VA 8. Date of Birth (Month, Day, Year, March 15, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🖾 F 219-18-7496 87 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director Prince George's Hvattsville 1 X Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral 5814 33rd Avenue 20782 within 72 hours after death with USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher 1 and 2 should be filed within the strength and Mental Hygiens item 27 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Poulson William Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven P. Hajdasz / Son 5814 33rd Avenue, Hyattsville, MD 20782 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 5/4/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Part 1 onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Pregnant at time of death 1 Yes 2 Jud cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Determinent On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and phase, and other the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATER HARKY

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend 18 per FD, Registra DOR, 5/10/11, LDB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margie Todd Jones 2011 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner amor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 19 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Months Min. 1 □ M 2 🕱 F Davs Hours 213-22-7797 84 Jàn. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show MD Dorchester Cambridge 1 X Yes 2 □ No Funeral Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 307 Shepherd Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) invoice clerk permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the once. wire cloth mfg. 18. Mother's Name (First, Middle, Maiden Surname)
Ovelia
Ophelia Pritchett 17. Father's Name (First, Middle, Last) Be Purnell Todd 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Wheatley Jr. nephew 108 Merrily Drive, Troy, AL 36079 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Dorchester Mem. Park 5/10/11 4 Donation Cambridge, MD 21. Signature of Funeral Service kicensee 22. Name and Address of Facility Thomas Funeral Home P.A. hU 700 Locust St., Cambridge, MD 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vinery 12 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I∐Yes 2⊠No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1 ☐ Yes Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ၉ Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Q M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

408

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5068 2. Date of Death 3. Time of Death Physician/ Diane Kephart 2 rear 1206 AM 40ri Medical 4a. Facility Name (if not institution, give street and number) 4b. Qity, Town, or Location of Death 4c. County of Death **Examiner** Shadygrove Rockville Montgomery Adventist Hospita If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🖫 F 02/20/1988 216-31-2854 **Director** 23 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No MONTGOMERY MD BOYDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21031 CLARKSBURG ROAD 20841 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No "natural", Specify: WHITE 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TRACY LEE KEPHART MARY ELLA REED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACY KEPHART / FATHER 21031 CLARKSBURG RD., BOYDS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BOYDS CEMETERY 05/04/2011 BOYDS, MD 4 ☐ Donauro. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Ogset and Death Immediate Cause (Final Myocardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 00063163

2

DHMH 17 Rev 7/2009

Registrar

Adventit Hospital 9901 Medical Conter Drive, Rockerlle MD 20850

Shady grove

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.0

Stephen Nyuyen,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				State of Ma	i yianu	Certifica				eg. No. ()	- Annual of A	159	69
	Physicia		1. Decedent's Name (First, Middle, Lest, Kenneth Stanley						2. Dete of Dear	h Day 24	Year 2011	3. Time of 9:12	
A STATE OF THE PARTY OF THE PAR	/Medic Examin		4a Fecility Name (If not institution, give	street and number)			- 1	4b. City, Town, or	Location of Death	4c. County Fred	of Death		
	Funeral Director		5. Social Security Number 6. Sec. 102 - 32 - 3663		(In yrs. las	Yrs. If Und Months	er 1 Year Days	Hours Min		Year)		ice (State of	r Foreign
	ath with the Maryland 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Frederick		•	Town or Location	le					d. Inside Cit	•
	th with th	Funeral Director	10e. Street end Number 9 Liberty Street				ip Code 2/79.	3	1	10g. Citizen of Whet Country! Unifed Stu			
020	urs efter des M', or items ixaminer m	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp		lispanic Origin? () an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Yes or Non, etc.) 14. Race - Ame Black, Whi				
21215-0020		Completed	15. Decedent's Edu (Specify only highest gredi Elementary/Secondary (0-12)			16a. Decedent's Us (Give kind of w life. DO NOT	vork done use retire	during most of wo	orking	16b. Kind of Bu		ıstry	
Maryland 2	uid be filed fantal Hygi rked other tic evant, I	To Be C	17. Father's Name (First, Middle, Last) Stanley E. Keef	er					Name (First, Middle, Maiden Sumame) A. Bauerline				
	d 2 sho th and 7 is ma traum		19a. Informant's Name/Relationship (Ty Debra R. Keefer	vpe, Print) Wife		19b. Mailing Addre						2ode)	
Baltimore,	Pages 1 an nant of Heal int: If Itam 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify)			ce of Disposition (N netery, crematory of U/PPA (CMC	ton		May 6,2011	20c. Location - Gety burg	9, PA		
Balt	parmit. Page Depertment of Important: If any injury or ance.		21. Signature of uneral Service Licens	Mul	le	22. Name: Wetz	and Addre	ss of Facility	Vom 54	9 Carlo	sles	H 13	Hover 1331
1	Physician		23 Ferm. Enter ne disease, or compl shock, or heart failure. List only or	ne cause on each line	e. 			,			,	Approximete Interval Bet Onset and I	ween
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	. metast		as a consequence of		he (Cancer			/ n	1
°,	ifficate be executed g physicien end as the buriel-trensit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause Disease or injury										
x 68760,	₽ 9 0	< □	resulting in death) Last	d	Due to (or as a consequence of):								
Вох	death cei e attendir ed for usa	clan	Part II. Other eignificant conditions con	atributing to death bu	t not result	ing in the underlying	rance di	en in Part I	23b. Did to	obacco use co	ntribute to	the cause	of death?
, Р.О	£ ŏ ♥	by Physician/							1 🗆 Y			ably 4□	
of Vital Records,	e law requires has been sign ga 2 should be	Completed b							24a. Was e perfor		avai	re autopsy f ilable prior t npletion of c leath?	to
<u>س</u>	: The la								101	as 2 No	10	Yes 2	No
Zit.	3 0 5	Be C	25. Was case referred to medical examiner?	Hospital:	4 ADE	DAC-denotions 201	Ott		eath (Check only of Home 5 Resid		er (Specify	·)	
ion of	Attending Physic death. Sector: After this by the funeral di	ation: To	1 Yes 2	1 ☐ Inpatier 28a. Date of Injury (Month, Dey		R/Outpatient 3 10 R8b. Time of Injury M	28c. Inju		28d. Describe h			,	
Division	To the Hospital or Attending Phywithin 24 hours aftar death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, © City or Town, State)								
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of and manner stet	examinatio	edge, death occurre on and/or investigation	d at the tir on, in my d	me, date and place opinion, death occ	e, and due to the curred at the time, o	ause(s) and ma late and place,	anner as sta and due to	ated. the cause(s	s)
	To the To the comp	¥	29b. Signature and little of certifier	MD		2	9c. Licens	se number	14	9d. Date signe	11		
	WIL		Name and address of person who co		bath (Item 2	23a) (Type, Print) 50 W	77	h stre	et Freo	lerick,	, MD	217	0
	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 2	32. Registre	r's Signatu	A ha	Ked						,

11-03114 Sung Kwack Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ung Kwack	1- For State	/ Department of Healt Certificate of Death		Reg. No.	1 15970					
Physician/	1. Decedent's Name (First, Middle,Last)		l M	ate of Death onth Day Year	3. Time of Death 0546 hrs					
Medical Examine	Sung Yeung Kwack 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	Suburban Hospital	Bethe		Montgomery						
Funeral	5. Social Security Number 6. Sex 7. Ag	Months	Davis Usura Min	Date of Birth (MM/DD/YYYY) 9. Bi	gn					
Director	547-66-4202 1XM 2F	74 Yrs.	M	arch 15,1937 c	ountry) Korea					
w ny	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits					
faryland 28a-f show Lat once. ector	Maryland Montgomery		Potomac		1 Yes 2 No					
the Maryland or 28a-f sh iffied at one	10e. Street and Number	10f. Zip	20854	10g. Citizen of What Co.	-					
- 2 -	8509 Scarboro Cowt 11. Marital Status 12. Was Decedent	Ever in U.S. 13. Was Deceder	nt of Hispanic Origin? (Specify	Yes or No- 14. Race - Ame	rican Indian, Black,					
r death with or items 23 must be no		X No	Cuban, Mexican, Puerto Ricar		Actoria					
ral", on iner	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con		X No specify: Occupation (Give kind of work of		Asian					
72 hour	Elementary/Secondary (0-12) College (1-4 or :	during most of work	ring life. DO NOT use retired)		,					
5-0036 ed within 72 hour lygiene. other itan "natu he Medical Exar Completed	5+	College P	9	t, Middle, Maiden Surname)	ation					
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner To Be Completed by	17. Father's Name (First, Middle, Last) Yong Dal Kwac	b	18.Mother's Name (Firs	Su Bo Lee						
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other tt injury or other traumatic event, the Med To Be Comi	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	•	Route Number, City or Town, Stat						
MD and 2 sho salth and 2 sho salth and 27 is raumat	Myung H. Kwack - Spouse 20a. Method of Disposition	8509 Scart		e 20c. Location - City o	20854					
Baltimore, permit. Pages I ar Department of Hei Important: If ite	1 Burial 2 X Cremation 3 Removal from St	ate crematory or other place)		2/2011 Brentwood	Manuland					
altim nit. Pa sartmen Sortani	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	101564 22. Name and A	Address of Facility Hines -	Rinaldi Funeral	Home, Inc.					
	I MULLICA BU TELCILODO	11800 N	ew Hampshire A	ve., Silver Spr	ing,MD 20904					
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.		f dying, such as cardiac or resp	oratory arrest, snock, or neart	Approximate Interval Between Onset and Death					
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Smoke inhalation Due to (or as a constitution of the condition of the cond				+					
_	Sequentially list conditions, if any, leading to immediate Due to (or as a const	equence of):								
nsit Examiner	cause. Enter Underlying Cause									
	events resulting in death) Last Due to (or as a const	equence ory.								
ं तता.≃	UNPENDED AMENDED AMENDED 23d Date of deliv									
	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcor 1 Live birth	me of pregnancy 2 Fetal death	3 Ectopic pregnancy	23d. Date of delive Month	ry Day Year					
	past 12 months?	t time of death 5 Other (Spec								
the d		th but not resulting in the underlying	cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?					
i, P.O. ires that the signed by I be detach				1 Yes 2 No 3 Pro	obably 4 🗹 Unknown					
cords, law requir has been s 2 should i				autopsy prior to	utopsy findings available completion of cause of					
tal Records, linia: The law requires certificate has been signector, page 2 should be Be Completed					es 2 No					
ital sician:	25. Was case referred to medical examiner? Hospital:		OA Other Nursing Ho		er:					
1 of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should on: To Be Completee.	27. Manner of Death 28a. Date of Inju. (Month. Day.)		8c. Injury at Work? 28d.	Describe how injury occurred ject involved in housefire						
ision Attendiar death. rector: // by the fi	2 Accident Investigation Apr 24, 2011	0450 hrs	1 Yes 2 No		ural Pouta Number City					
Subject involved in housef Pound: The part of the p										
9 = 3 > 1 298. Certifier 4 9 45 1 Bit 1-1-1 To the heat of multipopulation death accurred at the time date and place and due to the cause(s) and manner as stall										
To the Howithin 24 h. To the Funcompletely	time, date and place, and due to a 29d. Date signed (M									
15 2	29b. Signature and title of certifier	7.)	O.C.M.E.		,,					
'	30. Name and address of person who completed cause of o									
		Medical Examiner 900 W.	Baltimore Street, Baltin	nore, MD 21223						
State	4 MAV 0 9 9011 (2)	ar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? | | 15971 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month Wanda A. Kuhn 20 6:30 A March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Mary's House If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 4, 1913 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🗶 F Hours St. Paul, MN Director 475-24-3822 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 United States 600 Veirs Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Caucasian 1 Tes 2X No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Medicine Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Catherine Mika Francis Miskowicz and is mis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 1105 N. Sycamore Street, Arlington, VA 22205 William P. Kuhn, Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 7, permit. Page 1 a
Department of H
Important: If ite
any injury or ott 201 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Arlington National Cemetery May 24,2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **6 hr** shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 yrs Cerebrovascular disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 X No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0022864 March 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James H. Millman, 8901 Wisconsin Avenue, Bethesda, MD 20889

State

Registrar

31. Date filed (Month, Day, Year)

MAY 02 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'Brien Littin 26, 2:30 A M April 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5105 Duvall Drive Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Min. Hours Oct. 24, 1928 New York Director 133-46-6815 82 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Md. Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5105 Duvall Drive 20816 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Broker Real Estate Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Joseph O'Brien E11en Crowley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C.J. Sherden / Son P.O. Box 236455 Cocoa, Florida 32923 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 28 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. $\overline{2011}$ Alexandria, Virginia 21. Signature of Funeral Service Linensee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Colon Cancer Months) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò 5 Other (specify) Month Day Vear Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 2 🛣 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending X Natural Division within 24 hours after death.

To the Funeral Director: After After After Indian 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month. Day. Year) D0006493 aureme April 26, 2011

State

Registrar

5550 Friendship Blvd. Chevy Chase, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

Lawrence Widerlite

MAY 02 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraAMEND#23e+24apenND,5/6/11;BMW,McGertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 29, Day 2011 Physician/ 11:04 p M Aleksandr Lyubarskiy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16104 Crabbs Branch Way #32 Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 1 X M 2 □ F Hours 3/27/32 Ukraine 79 215-39-2777 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Battimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Ves 2 □ No Montgomery Rockville Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 16104 Crabbs Branch Way #32 IIS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 K Married 1 ☐ Yes If Yes, Give 2 🔀 No 1 Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Electrical EngineeringProfessor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pincus Doba Malkin Lyubarskiy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyubarskaya/Wife 16104 Crabbs Branch Way #32 Rockville, Md. 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 5/2/201 Olney, Md. Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Edward 22. Name and Address of Facility
Danzansky Goldberg
1170 Rockville Pike Memorial Rockvill Chapels e. Md. 20852 Edward Sagel M00910 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year been signed by the s 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No After this certificate funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: At Joompleted filled in by the fu Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

Registrar

State

Manish
31. Date filed (Month, Day, Year,

MAY 03 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manish Argawa1

32, Registrar's Si

G2234

4/30/2011

9707 Medical Center Drive Suite 300

Rockville, Md/ 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf g919 9-26-11 vt
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 920AM Apri 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Count Doctors Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Min 03/10/1963 1 DM 2 DF 48 Director NY 292-17-0586 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges 1 X Yes 2 No MD Bowie County 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 14123 Pleasent View Dr 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried ☐ Yes 2**X** No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morris J. Louis Roslyn Kimel 19a. Informant's Name/Relationship (Type, Print) Kimberly Kay Johnson Louis Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14123 Pleasent View Dr Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. HeBron Cemetery 04/28/2011 Flushing, NY 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel, Inc. 1170 Rockville Pike Rockville MD 20852 21. Signature of Funeral S MO1163 23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Renal Cell Carcinoma Medical Due to (or as a consequence of Examiner Brain Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ie attending physician and ed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Esophageal Cancer that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 💢 No Other: မြ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 10 4-26-2011 who completed cause of death (Item 23a) (Type, Print) 8118 LANhAM Good Luck Koyc State MAY 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Faye Marsha LICHBACH 11:07 P M April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Silver Spring 904 Brentwood Lane Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Hours **Director** 58 1952 Iffinois 320-46-9744 Nov. Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Silver Spring Montgomery Maryland 1 Tes 2 X No 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? 20902 Funeral 904 Brentwood Lane iral", or items 23a Examiner must b United States Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. If Yes Give Specify: Completed 3 Widowed 4 Divorced er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the Ā Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gladys Pinsker Sidney Sharp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Brentwood Lane, Silver Spring, MD 20902 Mark Lichback, Husband permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eretz HaChaim Cemetery 05/03/11 1 N Burial 2 Cremation 3 N Removal from State 4 Donation 5 Other (Specify) Mifgash Shamshon, Israel 21. Signature o Funeral Service Les Torchinskys Hebitew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, i i n Malignant Neoplasm of Breast Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-thinsi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2X No 4 Pregnant 9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death ed by the a 1 L Yes 2 signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 \square Yes 2 🗌 No Accident Investigation npleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. IC 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STA-UNHARM 600 street 31. Date filed (Month, Day, Year) State Registrar

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			1 - State Registrar AMEND#10epe					,	Reg. No. 2	15976
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	Examir	ier	4a. Facility Name (if not institution, give		Hospita		r Location of Death		4c. County of Dea	1
	Funeral	г	to ward Count 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birt		thplace (State or Foreign
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	yland f shov ed at	ţo	10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
	he Mar or 28a notifi	Dire	Maryland Howard 10e. Street and Number	#331	Colum	10f. Zip Code			10g. Citizen of What C	1 Yes 2 XNo
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral Director	7110 Minstrel Way	#313		210	4 5		Howard	Surfix y .
(0	er deatl or iten niner n		11. Marital Status 1 □ Never Married 2 汉 Married	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No			Hispanic Origin? (Sp an, Mexican, Puerti		14. Race - Ame Black, Whit	
003	urs afte tural", al Exar	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates. WW	II	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
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121	d within lygiene. ther thar nt, the M	Be Co	12	College (1-4 or 54)	Own	er	1		Camera C	enter
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Edward Lenet				Rose	Robinso		
Ma	d 2 shou alth and 27 is m ir traum		19a. Informant's Name/Relationship (Ty) Steven Lenet, Son	oe, Print)			and Number or Ru Brook Ct.		; City or Town, State, Zi	_
ore,	je 1 and t of Heal if item 3 or other		20a. Method of Disposition 1 Å Burial 2 □ Cremation 3 💢	Removal from State	0b. Place of Dispo			Date	20c. Location - City or	Town, State
Itim	t. Pa tmer tant ijury		4 ☐ Donation 5 ☐ Other (Specify	<u>K</u>	ing David		al Garden ⊁≈Hebmew			hurch, VA
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	Medical Examiner	2 2	23a. Part + Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the e cause on each line. a	onia	er the mode of dyli	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
00	te be executed sysician and ne burial-thansit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or unjury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor						
. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate be executed. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit.	Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of de Month	livery Day Year
Division of Vital Records, P.O.	ires that t signed b Id be deta	d by P	Part II. Other significant conditions collections with the conditions collection and the conditions collections are conditions as a condition of the conditions are conditions as a condition of the condi	ritributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.		bacco use contribute to	the cause of death?
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:	n 24 ho n 24 ho ie Fune sleted fi	Medical	(Check 2 \(\superpressure \) Medical Examin	cian: To the best of my ker: On the basis of examine Practioner: To the best	nation and/or invest	igation, in my opini	on, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier							
	12+1		30. Name and address of person who co	mored cause of death	(Item 23a) (Type P	rint)	15653	1	May 01	, 2011
			Harry Li, 86	00 Snowd	len Riv	er pku	14 #301	, Colu	mbia, m	n, Day, Year) , 2011 D 21045
	Stat Registra		31. Date filed (Manth, Day, Year) MAY 03 2011	39. Registrar's S	ignature .	N. S.	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 28° William McIlwee LeRoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1324 Fairchild Avenue Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Jan. 24, 1955 Months Hours 215-62-2632 56 Yrs Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1324 Fairchild Ave. 21742 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Diesel motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sally John Morris McIlwee Lochte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Rogers / sister 821 Ropp Dr. #B/Martinsburg, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gravel Springs Cem. May 2,2011 Gravel Springs, VA 21. Signature of Furneral Service License 22. Name and Address of Facility Stauffer Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hepatocellular Carcinoma (metastat disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transi that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hepatitis C Records, Completed page 2 should 24a. Was an autopsy performed this certificate Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier nthea Kuttnew Sands no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVATRICA KUHART - Sands ND Hospice of Washington County

1621 Opossumtown Pike/ Frederick, MD 21702 Approximate Interval Between Onset and Death lear. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) April 28,2011 747 Northern Avenue Hagerstown Maryland 21742 32. Registrar's Signature Barker **ORIGINAL**

3. Time of Death

 A^{M}

6:00

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Maryland

2011

Washington

Black, White, etc

25403

White

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day Year)

23d. Date of delivery Month Day Vear 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🔁 No Dove Hour 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster MO 21157 291 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

2149

9. Birthplace (State or Foreign

10d. Inside City Limits

White

Approximate Interval Between

Onset and Death

1 Yes 2XX No

Country) Panama

Black, White, etc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Rita L. Moore May 4:30 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 Director 516 22 4767 89 July 15. Montana Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Prince George's Camp Springs 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 6703 Geneva Lane 20748 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 1 Never Married 2 Married Yes 2 No Yes, Give XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anthony Loebach Caroline Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trac William Moore (Husband) 6703 Geneva Lane, CampSprings, MD 20748 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 5/9/2011 Clinton, MD 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Ricenses Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Sepliamy disease or condition Unknown Medical resulting in death) or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ april ancunysm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page death? 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury within 24 hours after death.

To the Funeral Director; A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number Roth Th M.O. D4 3446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARAHIFAR 12150 Anapolis Rd Snih 312 Glandle MO 20769

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 30 2011 Mamish 6:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Sept. 20, 1917 Hours Country)
West Virginia 93 Yrs. **Director** 232-05-2073 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9644 Traville Gateway Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Mamish Frances Stradiot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waskewich Walter Skewiski/Nephew 9644 Traville Gateway Drive, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7, 2011 Davis, WV Davis Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Risan M= Millian MO1202 10 East Deer Park Drive, Gaithersburg MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Maxime acute Cerebro vascular

Due to (or as a consequence of):

acuteut Onset and Death Immediate Cause (Final hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, e attending physician and ed for use as the burial-ransit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day 1 Yes 2 4 9 Unknown n signed by the a ld be detached f 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. . Completed by ictros pulmo Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed page 2 s prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician:
within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practiciner to the basis of my knowledge, death occurred at the time date and place and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number ▶ K- Rehert Dirschb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELLAVENUE

(LROBERT & (RSCHBALH, MA EALTHERS URG, MA 2087) 04115 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

MAY 03 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month William Edwin Mould May 3:35 р М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) D • C • 8. Date of Birth **Funeral** 1 X M 2 🗆 Hours Min Jan. Pay Year 919 Director 92 Yrs. 579-10-6697 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director MD P.G. Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a 3142 Gracefield Road, Apt. MG511 20904 USA n "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 75 ment of Health and Mental Hygiene. U.S. Dept. of the Elementary/Seconday (0-12) College (1-4 or 5+) Special Agent Treasury 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Mould Alice Mould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen S. Mould/Wife 3142 Gracefield Road, #MG511, Silver Spring, MD 20904 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)

11. Olivet Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signatura Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition End-Stage Dementia yrs. Medical resulting in death) Examiner 2 mos. Status Post Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) e attending physician and Examin the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year 2 🗌 No 9 Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To use incorporation after death.

To the Funeral Director, After this certificate has the completed filled in by the funeral director, page 2 s. performed? Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 🛚 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Julaine Harding, CRNP

31. Date filed (Month

3110 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	eartment of Health and Martificate of Death		201	1 15000
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate or Death	2. Date of Deat	eg. No. 👇 🤍 📗	3. Time of Death
	Physicia Medio		Earl C. Martin		Month 04	Day Year 201	0
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
in only			6600 Louise Street	Lanham			Georges
	Funeral Director		5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 05/20/1	Year) Co	thplace (State or Foreign ountry)
_			578–52–9083 70 Yrs. Usual Residence of Decedent		_05/20/1	1940 Was	shington, DC
	fand shov	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD Prince Georges Lanham			_	1X Yes 2 ☐ No
	th the	al D	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	ath wi	Funeral	6600 Louise Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20706 Was Decedent of Hispanic Origin? (Spe	oify Voc or No	USA	
(O	er dea or ite niner	by F	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - Ame Black, Whit	
ĕ	rs aft Iral", Exal		1 Never Married 2 Married 2 Married 1 Never Married 2 Marr	1 ☐ Yes 2 🖾 No Specify:		Specify: B1	.ack
21215-0036	2 hou "natu adica	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	na	16b. Kind of Business	
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	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Be (12 Tr	ain Driver 18. Mother's Name			sit Authority
au		To	Cuther Martin	Bernice		aden damame)	
Maryland	should by and Mer is marke aumatic			ing Address (Street and Number or Rura		City or Town, State, Zij	o Code)
	47.4		Arlene V. Martin/Wife 6600	Louise Street La	anham, M	D 20706	
Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of pattern of place)	ate 2	20c. Location - City or	Town, State
Ē	nit. Page artment c ortant: If injury or e,		4 Donation 5 Other (Specify) Ft. Linco	1n Cemetery 05/06	/2011	Brentwood	i, MD
Bai	permit. Departr Imports any inji		Maria Maria (hallo			n Funeral	
	40 = 10 0		23a. Part I Enter the disease, or complications that caused the death. Do not en	401 Bladensburg Ro		entwood, M	
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac of	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Phy i i n Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	scular accident			Silact and Death
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	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.	mollistus			here than
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ROX	eath c atter	iciaı	in the past 12 months?	Ctopic pregnancy Other (specify)		23d. Date of del Month	Day Year
n	the de by the ached	hys	9 Unknown 9 Unknown				
л Э	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. With In 44 hours after death. Completed filled in by the funeral director, page 2 should be detached for the funeral physician after this completed filled in by the funeral director, page 2 should be detached for the funeral director.	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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Records,	law re las be	Completed			24a. Was an autopsy		topsy findings available completion of cause of
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Vital	ician certifi rector	m	25. Was case referred to medical examiner? 1 Ves 2 No Hospital:	26. Place of Death (Check	. /		
01	Phys r this aral di	은	1	nt 3 □ DOA 4 □ Nursing Hor	ne 5 M Resider 8d. Describe how	ce 6 Other (Spec	ify)
Z Z	nding ath. r: Afte e fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	od. Describe novi	mjary occurred	
DIVISION	• Atte er deg ectol by th	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		et and Number or Rui	ral Route Number,
5	To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be det				City or Town,	•	
	Hosp 24 hou Funel ted fil	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation).	tigation, in my opinion, death occurred at t	he time, date and	place, and due to the	cause(s) and manner stated.
	ithin 2	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title Ocertifier	death occurred at the time, date and place 29c. License number	, and due to the c	ause(s) and manner as	stated.
	ř ≥ř ŏ				29	d. Date signed (Month	i, Day, rear)
,		ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type,		10	pland	0 //
1	20		James J. Kim, M.D. 10694 Campu		go, Mar	yland 20	774
Ė	Stat	_	31. Date filed (Month, Day, Year)				
	Registra	r	MAY 0 5 2011 Senera D. Mailes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paula Antonia Loaiza De Noriega 2011 Medical 4b. City, Town, or Location of Death Cheverly County of Death Prince George's 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Medical Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours 61/93/10/1/941 69 Gwatemala 216-64-4953 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Rockville 10a. State 10b. County 10d. Inside City Limits **Funeral Director** MD Montgomery 1 🗆 Yes 2 ื No 10f. Zip Code 20850 10e. Street and Number
215 Elizabeth Avenue 10g. Citizen of What Country? Guatemala 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1

Yes 2 □ No Specify: Guatemalan Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Juana Samayoa Amelio Loaiza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Elizabeth Avenue Rockville, Md 20850 Evelyn Motta/Daughter 20a. Method of Disposition 20c. Location - City or Town, State Guatemala City, 20b. Place of Disposition (Name of 1 K Burial 2 Cremation 3 Kempfal from State Las Flores Cem. 5/7/2011 4 Donation 5 Other (Specify) Guatemala 21. Signature Fyneral Service Lice PHTEIP D: REWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Fatal arrythmia Medical Due to (or as a consequence of): Examiner cute rena if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): e attending physician and ed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastaticcancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed eral Director. After this certificate filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after Funeral Direc Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) ρ မ 22396

State

Registrar

erv

31. Date filed (Month, Day, Year)

Matin

02

DRIVE

HOSPITAL

person who completed cause of death (Item 23a) (Type, Print)

300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** Alice Virginia Outten 2011 3:25 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 14,1922 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F Sept. 215-12-6012 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show arthan "natural", or items 23a or 28a-f show the Medical Examiner must be motified at MD Dorchester Cambridge Directo 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Academy St. 21613 USA Apt. 103 Funeral Baltimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐Yes 2 🛣 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, Item 2000. owner/operator beauty salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nolan J. McCarter Alverda Green ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin F. Outten III son 1417 School St., Cambridge, MD 21613 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dorchester Mem. Park 5/11/11 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** oneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dementia Sequentially list conditions, if any, leading to immediate cause. Enter thin entity in Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) the detached 9 Unknown þ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ✓ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After this funeral c 27. Manyrer of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division of Vital Records, or Attending Physician: The within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospital

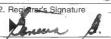
> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier



100 Bramble

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene 2 0

1 - State Amended #18perFH FCHD KS 5/2/1 KS ficate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29 Bay APRIL ELEANOR SEQUEIRA OXENDINE 2011 6:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ROCKVILLE CASEY HOUSE HOSPICE 8. Date of Birth (Month, Day, Year) 08/15/1937 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Days Min. Hours Director Yrs. 73 KY 404-46-5368 Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No MONTGOMERY GERMANTOWN MD 10e. Street and Number 23a or 10g. Citizen of What Country? by Funeral 19216 FOREST BROOK RD. 20874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 9 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 - Widowed 4 - Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE Be event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ROSO CAETANO ROSA CAETANO AVILINO SANTOS SEQUEIRA permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19216 FOREST BROOK RD., GERMANTOWN, JOHN OXENDINE / SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State D5/03/2011 BOYDS, MD BOYDS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature Funera Service Licens 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BILIARY CIRRHOSIS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day 1 Yes 2 0 After this certificate has been signed by the funeral director, page 2 should be detached P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy autops, performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ၉ 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After the Hospital or Attending (Month, Day, Year) 1 🛚 Natural Natural
Accident
Suici 5 Pending injury 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License number R 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRAH MILLER, CRNP, 6001 MUNCASTER MILL RD., ROCKVILLE, 32. Registrar's Signature State backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sidney Ronald Osnos 1.41 P. M 2011 Medical Apri 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Yea 369-20-3879 1 🔀 M 2 🗆 Months Days Hours **Director** 84 Michigan 1926 Oct. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified MD 28a-f Montgomery Rockville 1 Yes 2 No "natural", or items 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 299 Hurley Avenue 20850 United States death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 - Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be Osnos Florence Pollock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Noah Osnos/Son 47 Irving Place, New York, NY 10003 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State George Common in the Sity Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, F.A. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) phehmony Medical Due to (or as a consequence of) Examiner bronchiti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or). certificate has been signed by the attending physician and isomer nage 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 2 № No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier P 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Rocky, He Mid MD 100 31. Date filed (Month, Day, Year) . Registrar's Signature State MAY 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarAmend#2 perMD FCHD 5/4/11 LECertificate of Death Reg. No. 7 1 1 2. Date of Death Apr 27, 2011 April 26, 2011 3. Time of Death Physician/ Khushaldas Prabhudas Patel 4:40 am M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Germantown 4c. County of Death
Montgomery 17211 Snow Goose Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**¥2**¥M 2 □ F Days 321-94-5552 81 Hours Director India Aug Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 17211 Snow Goose Court 20874 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ģ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Indian Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Khushaldas Patel Ugariben Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natvar Patel - son 20874 17211 Snow Goose Court, Germantown, Maryland t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I-Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Stauffer Crematory 4-30-2011 4 Donation 5 Other (Specify) Frederick, Maryland Signa re of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility same 21702 Opossumtown Pike, Frederick, Maryland 1621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sma Prosiciano disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence oi). attending physician and for use as the burial-transil To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical B B 26. Place of Death (Check only one) 1 Tes 2 **N**0 Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) MD D0066990 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinni Juneja, MD19731 Germantown Road, Germantown, Maryland 20874

State

Registrar

31. Date filed (Month

egistrar's Signatur

College of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 5/6/11 Amended 29d & 30 ekt Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year CAMONT 1928 2011 Ma Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Albo Memoria ASTON Age (In yrs. last birthday If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours Min Director Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Ton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNIT Funeral with items 23a Man's 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 6 9 1 Yes 2 No Specify If Yes, Give than "natural", Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Health and Mental Hygiene. Flooring Installation ntrepreneur is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Boyce ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 906 Easton MD. 21601 Pritchett Michelle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greensboro, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, R.A. Cambridge MD, 21613 23a. P. 1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Secus tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No within 24 hours are death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Unknown P.O. er significant conditions death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 4a. Was an autopsy perform 1 ☐ Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be Division of Vital 26. Place of Death (Check only one) Hospital: 유 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28a 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check g Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a d title of cert rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 209 S. Washington St Easton MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frank Pless Month Apri] 2011 11:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 180 Ritchie Highway, Room# Anne Arundel Severna Park 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17, 1926 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 - F 84 216-20-4191 Director June Usual Residence of Decedent 28a-f shov 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 180 Ritchie Highway, Room# 326 21146 USA 12. Was Decedent Ever in U.S Armed Forces? 19 1 X Yes 2 No 19 If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1944 Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1946 White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 🗓 Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Sales Sears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Pless Suzanna Kiefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Westminster Way Annapolis, MD 21401 and 2 s Health s John J. Poiter / Stepson item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel y 03, 2011 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Brooklyn Park, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwv. 21. Signature of Funeral Service Licenses Ritchie Hwy, 23a. Part | Enter the dise r e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, r icon the irre. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ?hysician/ MYO CardIAL disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 ding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown o in the past 12 months? 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 No 1 Yes 2 No Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify s after death.

I Director: After this d in by the funeral d of 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 5 Pending Division 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title o 29c. License number april 29 2011 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) ndermed Blus #330. Lamborks strar's Signature 3 Registrar

DHMH 17 Rev 7/2009

Amended Item 5 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 5990 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 30, 2011 Anna Prozialeck April 0250 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Lorien Nursing Home Taneytown If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Dec 28, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 2013 Sacrity 21119 **Funeral** Days Months 1 □ M 2 🕶 E 88 Director PΔ 205-16-2199 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director MD Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013-2C Rudy Serra Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Elementary/Secondary (0-12) College (1-4or 5+) 10 Seamstress Best Form Foundation is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Vasil Rock Mary Corobanik ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 i any injury or other tra Gloria Stancovich/Daughter 220 Magers Dr. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 5/2/2011 Hampstead, Maryland 22. Name and Address of Face Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Ligensee 412 Washington Rd. Westminster, MD 21157 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician www. 6 mas /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-trar Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Tyes 2 No 3 Probably 4 Unknown Completed page 2 should been 24a. Was an autopsy performed?
1□ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate l or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division the Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Direct mpletely filled in by after 4 ☐ Homicide hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within To the ို 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Maryland /		artment of H		Mental Hyg	iene	ę		
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مسدر	-		9809 Golden Rus 5. Social Security Number		age (In yrs. last bir	th day)	Dunk If Under 1 Year	rirk If Under 24 Hrs	I o Data at Birth		ver		
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	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				10	Od. Inside City	Limits
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036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🛱 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	? □ No 1942-45	1:	Yes, specify Cubar ☐ Yes 2 🏋 No	n, Mexican, Puert	o Rican, etc.)	Black, V		tc.	
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Baltimore,	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		·~		atory or other place ans Cemete	· •	1-2011	Cheltenh	ıam.	MD	
Balt	permit. Page Department I Important: II any injury or		21. Signature of Funeral Service L	R- Gra-	~		Name and Address			neral Ho ngs, MD			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line.										Approximate Interval Betwe	en		
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	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of Nurse Programmer: Lethi	examination and/d	r investi	gation, in my opinion	, death occurred a	at the time. date and	place, and due to t	the caus	e(s) and manne	er stated.
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fa	WID		1 11 / 1	the completed codes of werthough	death (Item 23a) (Type, Pr	fal Rd, s	to 210	Rince Fr	ederick 1	48	2067	8
	Stat Registra		31. Date filed (Month, Day," Year) "	32. Regist	s Signature	A	bow o						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 Year April 26, Victor William Puma 7:10 p^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) July 24, Funeral 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Director Lima, Peru 216-81-2229 50 1960 Usual Residence of Decedent fshow 10b. County 10c. City. Town or Location must be notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland | Montgomery Bethesda 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10504 Montrose Avenue #102 20814 United States permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 No Specify: Completed 3 Widowed 4 Divorced Central/S. American Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) , Graphic Designer Architecture marked other matic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Health and Ment tem 27 is marked other traumatic e Maria Luz Rivas de Puma Daniel Puma Aparcana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonieta Sanchez, Spouse 10504 Montrose Avenue #102, Bethesda, Maryland 20814 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory May 3, 2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non small cell lung cancer disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-i Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Live Birth ∠ ☐ Fregnant at time of death
☐ Unknown Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 1 Tyes 2 🗌 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2
To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title & certifie 29d. Date signed (Month, Day, Year) D66990 -11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MITTIME

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Vinni Juneja, 6420 Rockledge Dr. Suite 4100, Bethesda, Maryland 20817

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Elementary/Seconday (0-12)	College (1-4 or 5	+)		NOT use retired) cutive S	ecretary		Insu	rance	1
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Box	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	У			Date of deli	very Day Year
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uc :	ath. r: Afte re fune	cate	1 Accident Investigat	(Month, Day,	Year)	injury	work?		zoa. Describe fi	ow injury occi	irred	
Division of	or After of a ster de la Directo	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry - At hom (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
)	to the Nospiral or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	ledical	(Check 2 ☐ Medical Exa	hysician: To the best of naminer: On the basis of exture Practioner: To the basis	amination a	and/or investig	gation, in my opinior	n, death occurred at	the time, date a	nd place, and o	due to the ca	ause(s) and manner stated.
	vithir To th	Σ	29b. Signature and title of certifier	/7	or my f		29c. License			29d. Date sigr		
	2	Į	Valla	col MD			D3131	9		04/25	/2011	
			30. Name and address of person wh	,	,		int)					
	State	9	Loreto S. Albio 31. Date filed (Month, Day, Year)	3. Registrar	218 W 's Signatu	iscons re	in Ave.,	Suite 30)5 Bethe	esda, M	D 208	14
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State of Maryland / Department of Health and Mental Hygiene	was not to	1 4 7 7

Enrique Carl Pascu	1- For State	State of	Maryland		rtment of		and N	Mental H	-	Reg. No.	4 4	1 (333)
Physician/ Medical Examine			arlos		Pascua	les			Date of De Month	ath Day	Year	3. Time of Death 1021 hrs
The Later La	4a. Facility Name (if	not institution, give str	eet and number			4b. City, Town		cation of Death	April 20,	4c.	County of D	Peath
Funeral	5. Social Security Nu	Adventist Hospita		ie (In vrs. la	ast birthday)	Takoma		If Under 24Hrs	Montgome 8. Date of Birth(MM/DD/YYYY)			
Director	212-08-	2208	2F	80	Yrs	Months [Hours Min.	_	1/19	i c.	oreign Colombia
any	Usual Residence of L	Decedent 0b. County		10c. Citv.	Town or Locat	ion						10d. Inside City Limits
≱	MD	Montgome	ry		ilver		g					1 Yes 2 X No
Baltimore, MD 21215-0036 Department of Realth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Numi	^{ber} ney Bran	ch Roa	d #2	0.7	10f. Zip Cod	903	}		_	en of What	•
with the no 23a o be notifi	11. Marital Status	12	. Was Decedent	Ever in U.	S. 13. Wa	s Decedent of	Hispan	nic Origin? (Sp	pecify Yes or N		14. Race - A	merican Indian, Black,
er death with , or items 23 r must be no Funeral		d 2 Married 1		X No		es, specify Cu	ban, me No <i>si</i>	Co	olombi		White, e Wh S <i>pecify:</i>	ite
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Physician	23a. Part I. Enter the	disease, or complicat	ions that caused	the death.								ring, Md2091 (
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. Box 6876 the death certificate by the attending phy ched for use as the Physician/M	1 Yes 2 No	4][time of dea	ath 5 Ot	her (Specify)						
Records, P.O. Box 6876(The law requires that the death certificate cate has been signed by the attending phy- page 2 should be detached for use as the b Completed by Physician/Me		cant conditions con	ntributing to deat	h but not re	esulting in the u	inderlying caus	se giver	n in Part I.		_		e to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirer safter death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Completed	<u></u>								auto perf	ormed?	deat	to completion of cause of h? Yes 2 No
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Sion (Attendin death. ctor: Ay the fur	1 Natural 2 Accident	5 Pending Investigation	Apr 20, 2011		0946 hrs			2 🗸 No	Pedestrian			
Division o spital or Attending nours after death noral Director. After filled in by the func Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In (Specify) Loc	100		et, factory, offic	e build		or Town,	State)		r Rural Route Number, City letzerott Road, Takoma P
		Certifying Physician:	To the best of m	y knowledg	ge, death occur							
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	30. Name and addres	ss of person who comp Assistant Medi			^{23a)} Penn Stree	et, Baltimor	e, MD	21201				
State	31. Date filed (Month)	Day Year)	32 Registra	r's Signaty	fer	W.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 20^Y1 1 3:45p Medical Evelvn Ruth Brown Rvnn 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Waldorf Center Waldorf Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min 8 -5 - 1 9 30 Director 400-40-1773 80 Kentucky Usual Residence of Decedent show or 28a-f shov notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No Maryland Prince George Brandywine 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? pe Funeral must I 4707 Danville Rd 20613 USA items 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Force Black, White, etc. Completed by ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 K No Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: White or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working id Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Military Pers. Spec. Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George W. Brown Mary Liza Langford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Langley/ Daughter 4707 Danville Rd, Brandywine MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 5-6-2011 Clinton Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral HomePa, Aquasco MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in part line. Approximate Interval Between Immediate Cause (Final Onset and Death ∾Ph_sician MBN disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner erosclatoTic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due o (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed Yes 2. No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 24 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 No Accident
Suicide Investigation
6 Could not be filled in by the 24 hours after deat Funeral Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. **To the F** 29b. Signature and title 29c. License number 29d. Date_signed_(Month, Day, Year) 2257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20602 CENTER , Mes Waldorf Mp OLDLINE Suite 302 31. Date filed (Month, Day, Year) 32. Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 2 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 29 Day Josef Peter Rad1 April 2011 1:25pm^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day Year Aug. 21, 5. Social Security Number 9. Birthplace (State or Foreign Country) Hungary 7. Age (In vrs. last birthday) **Funeral** 1 ፟፟፟፟ M 2 ☐ F 219-32-4619 Director 77 1933 Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director P.G. 1 Yes 2 TNo Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2405 Lewisdale Drive 20783 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1956–62 1 ☐ Yes 2 K No Specify: "natural", Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 all Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Barber Hair Stylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Peter Rad1 Anna Pravetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Radl/Wife 2405 Lewisdale Drive, Hyattsville, MD 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) May 4 2011 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemeterly Silver Spring, MD 22. Name and Address of Facility. Francis J. Collins Funeral HOme 500 University Blvd. W., Silver 21. Signa ure of Funeral Service License Inc. Spring MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death h sician מייי disease or condition resulting in death) a Recurrent Pneumonia dave Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) tending physician and ruse as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death the Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End-Stage Renal Disease, Dialysis, Diabetes Mellitus Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Hypertension, Atherosclerotic Cerebrovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate Yes 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗵 No Other: 12 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the Funeral Director: After the Tuleted filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty re and tithe of certifier 29c. License number 29d. Date signed (Month, Day, Year) am D53367 APril 29,2011

13,

DHMH 17 Rev 7/2009

State

Registrar

1500 Forest Glen Road,

Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Shyamsundar Rajan, MD

MAY 02 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:00 PM Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Regional Hospital Prince George Ldure if Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or **Funeral** 1 □ M 2 💢 F Months 82 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at Director Yes 2 No MD 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? traumatic event, the Medical Examiner must be 8706 20708 Funeral u.S. XWe items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ABlack, White, etc. Speciny: Can-American 9 ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) aucator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eirst, Middle, Maiden Surname, permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew မ Rand 19a. Informant's Name/Relationship (Type, Print) et and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Addres Workeman-20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory of 10,201 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 234. Part 1 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final /hysician HYPOXId disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Failure espiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and is the burial-transit e requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed 1 Yes 2 No rs after deam.
ral Director: After this ceruination by the funeral director, pr Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Tyes 2 No ပ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar aurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Lee-Llacer

31. Date filed (Month, Day, Year

MAY O

5 2011

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Hospital

Regional

Dusen Road

7300 Van

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh e916 6-10-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 2011 3:12 Рм Edward Hood Spurrier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. Mary Land MO773/1918 92 Director 220-09-Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No Frederick MD Brunswick 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 514 West Potomac Street 21716 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black White, etc. ò 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: "natural", 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Brakeman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဥ Lucy Hood John B Spurrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 514 West Potomac St. Brunswick MD 21716 Steve Spurrier, Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Park Heights Cemetery 5/4/2011 4 ☐ Donation 5 ☐ Other (Specify) Brunswick MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bartene John T Williams Funeral Home, Brunswick MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final - temácion/ Neumoni disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as Amnsequence of acres iRCI the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ó Pregnant at time of death the detached Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) f Death 28b. Time of 27. Mann 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Bruce 05 6:10 03 9011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Marc ORCHESTER AMBRIDG If Under 24 Hrs. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 1 M 2 □ F -38-4695 68 MARYLAND **Director** 08/19/1942 Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ir then "natural", or items 23a or 28a-f shout a Madical Examinar must be notified at 1 Yes 2 No Directo DORCHESTE AMBRIDGE nD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ROAD 1613 HATSAWAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ ₩6 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) in or Health and Mental Hygiene.

If Item 27 is merked other then or other traumette. College (1-4or 5+) RESOURCE CONSULTANT TECHNICAL KECRUITER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last, Be MARY HILEEN WILKINS WILLIA ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HATSAWAP ROAD CAMBRIDGE, ٤, AROLE STEEL 15 WD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of importent: If eny injury or once. 5/10 4 ☐ Donation 5 ☐ Other (Specify) CHRIST CHURCH GRAVEYARD AMBET DEF. MID SHORE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CREMATION FLORE LA D CEUTER BY QUEEN CURRAN Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** years Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): • Hospital or Attending Physicien: The law requires that the deeth certificate be executed by the burst after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use es the burlansit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 🗹 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated

State Registrar

Year)

29b. Signature and title of certifier

Name and

31. Date filed (Month, Day,



ddress of person who completed cause of death (Item 23a) (Type, Print)

'ah115011

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Victor F. Schuler April 2011 5:22 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 23 **Funeral** 9. Birthplace (State or Foreign Illinois 1 XM 2 □ Hours 82 1928 Director 358-12-9796 June Usual Residence of Decedent 28a-f shov 10b. County 10a. State Ħ 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Anne Arundel Arnold 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21012 USA 429 Stanford Court items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No 1951If Yes, Give 1953 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner ō 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 1953 Specify: "natural" 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Production Planner Aluminum Company 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Violet Jasinski Victor R. Schuler other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Stephanie Carboneau, daughter 429 Stanford Court Arnold, MD 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State ō Baltimore, MD injury Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
2 4 Cars Immediate Cause (Final -Physician/ Hdenocar cinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. id tobacco use contribute to the cause of death? þ pe Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should Was an 24b. Were autopsy findings available prior to completion of cause of 24a. has autops perfor death? certificate or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Man of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury within 24 hours after death.

To the Funeral Director: After Watural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier redical Parkney #210, Anopolis, no 2140/

State Registrar 31. Date filed (Month, Day, Year)